Escaping From Homelessness

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This thesis is submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology

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Declaration

This thesis is a record of original work carried out by me under the supervision of Dr Adrian Neal, Coventry University, and Dr Rachel Shaw, Aston University. The original idea for this work was my own and followed discussions with Dr Adrian Neal. Apart from the above collaborations, all the material presented in this thesis is my own work.

This thesis has not been submitted for a degree at any other university.

Summary

This thesis addresses the question of what helps the homeless to escape from homelessness. It comprises an empirical paper, a systematic literature review and a paper reflecting on the experience of conducting research with once-homeless men.

The empirical paper details a qualitative exploration of the experience of escaping from homelessness for five once-homeless men. Semi-structured interviews were carried out and analysed using interpretative phenomenological analysis. Emergent themes were: *life breaking in, decision to change, bad past* and *good present, better future. Life breaking in* considered how life events and relationships 'broke into' cycles of homelessness and drug abuse participants were caught in. Their combined effect seemed to be to bring participants to a 'turning point', where they made a clear *decision to change*. Participants' relationship with their past, present and future seemed key in maintaining their escape. Escape from homelessness was discussed in terms of identity change, especially the need to repair a broken identity.

The systematic literature review evaluates the evidence for the effectiveness of therapeutic communities (TCs) for dually-diagnosed homeless. PsycINFO, Web of Science, ASSIA and PubMed were searched using terms relating to *therapeutic community, homelessness* and *effectiveness*. A total of 113 unique articles were retrieved and of these ten met inclusion criteria and were reviewed. The review found that TCs with adaptations for patients with mental illness, in addition to substance dependency, led to small improvements in substance abuse, mental health and housing outcomes. However, these effects were short-lived and few were still present after a year.

In the reflective paper, the experience of conducting research, as a therapist, with once-homeless men was reflected on and the question of what therapists bring to research was considered. While therapists may struggle with some aspects of clinical research, they bring a range of skills and experience to this endeavour.

List of Abbreviations

C&S	Clean and sober
CR	Community residence
GAF	Global Assessment of Functioning
HIV	Human immunodeficiency virus
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative phenomenological analysis
ITT	Intention to treat
MTC	Modified therapeutic community
NHS	National Health Service
RCT	Randomised controlled trial
TAU	Treatment as usual
TC	Therapeutic community
UK	United Kingdom
USA	United States of America

Chapter 1: Empirical Paper

Escaping from Homelessness: An interpretative phenomenological study

Target Journal: ***British Journal of Psychology***

See Appendix A for Author Instructions

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1.1 Abstract

Homelessness is not a recent phenomenon, but has received little research attention. Although something is known about its causes, 'escape' from homelessness is less understood. This study explores the lived experiences of five men who have escaped from homelessness.

Semi-structured interviews were carried out and analysed using interpretative phenomenological analysis. Emergent themes were: *life breaking in, decision to change, bad past* and *good present, better future.*

Participants' escape from homelessness followed a low point, resulting from a complex mix of external and internal events, in the context of sustained and supportive relationships. Participants' relationships with their past, present and future seem to have been key in maintaining their escape. Whilst the past served as a reminder of what they could return to, their current lives, and their hope for the future, helped anchor them in their escape. Escape from homelessness was discussed in terms of identity change, especially participants' need to repair a broken identity.

Clinical interventions for the homeless should be available around low points and be long-term and relational in nature. Future research needs to explore the escape experiences of other groups, including women, children and young people, the elderly and those from other ethnic groups.

1.2 Introduction

Homelessness is not a new phenomenon in the UK (Timms, 1996) and, although accurate figures are hard to come by, the homeless charity Crisis estimates that the homeless total is around 800,000 (Crisis, 2008). Homelessness is associated with a higher frequency of a range of physical health problems and the homeless do not live as long as members of the general population (Flick, 2007). The homeless also have higher rates of mental health problems (Längle, Egerter, Albrecht, Petrasch, & Buchkremer, 2005) with substance abuse, especially of alcohol, being particularly high (Philippot, Lecocq, Sempoux, Nachtergael, & Galand, 2007).

1.2.1 Homelessness research

Phillippot *et al.* (2007) carried out a systematic review of research on homelessness in Western Europe and found that, although little had been done, most of it had focussed on establishing the characteristics of the homeless. Consequently, it is now known that Europe's homeless are: predominantly men, aged around 40 years, schooled to a low level, mostly unemployed, mostly unmarried and homeless for many years (Firdion & Marpsat, 2007; Leonori, Muñoz, Vázquez, Vázquez, Fe Bravo, Nuche et al., 2000; Muñoz & Vázquez, 1999). As regards the causes, research suggests that homelessness arises from complex interactions between a range of socioeconomic and personal vulnerability factors including: housing policy, unemployment, social welfare policy and immigration, the breakdown of social networks, addiction and loneliness, physical and mental illness, and traumatic life events (Philippot, *et al*., 2007).When the homeless themselves were asked about the causes of their

situation, there was a split between women and youth, who cited relationship problems, and men who blamed unemployment, eviction and financial problems (Muñoz, Vázquez, Bermejo, & Vázquez, 1999).

1.2.2 Escape from homelessness

There has been less research on what has helped homeless people to escape from homelessness, with most studies taking the form of quantitative evaluations of homeless services. Typical of these studies is Stergiopoulos, Dewa, Rouleau, Yoder and Chau's (2008) review of the progress of 73 men referred to a shelter-based mental health care team. Just two criteria were used to determine improvement at six-month follow-up: psychiatrist's impression of clinical improvement and being re-housed in the community. Both clinical and housing-status improvement were significantly associated with treatment adherence and number of visits to the psychiatrist. Housing outcomes were also significantly associated with a substance use disorder.

In a departure from this model, Patterson and Tweed (2009) asked 58 homeless and 80 once-homeless individuals to rate anticipated and perceived facilitators of escape from homelessness. The homeless group rated housing as the most important, followed by health-related services, food, dental care and transportation. The once-homeless group was asked to what extent each factor would have helped them when they were homeless. Housing was again rated highest, followed by food, social assistance funding, health-related services and training in resisting temptation. The once-homeless were also asked to rate another 31 factors according to how much they had actually helped them escape homelessness. Obtaining housing was rated highest, followed by 'hitting rock

bottom', 'realizing your potential', 'realizing your self-worth' and 'accountability for past decisions and current situations'.

Whilst less common, there were some qualitative studies which had conducted richer explorations of the experience of moving out of homelessness. Kirkpatrick and Byrne (2009) interviewed 12 participants with mental health diagnoses, who had been homeless and were living in supported accommodation. Adopting a narrative approach, they explored the experience of 'moving on' for once-homeless individuals with mental illness, after they had obtained permanent supported housing. Having stable accommodation and social support enabled them to 'move on', helping them to re-establish family relationships, gain employment and plan for the future.

In another qualitative study, looking at the routes through and out of homelessness, McNaughton (2008) interviewed 28 people who were, or had recently been, homeless. A key emergent theme was participants' substance use and its relationship with their homelessness. Although 19 were re-housed by the study's end, their 'rehabilitation' was far from complete – they reported continuing to feel marginalized and isolated and most continued their problematic substance use.

These last two studies give a greater sense of the experience of moving out of homelessness, although both still operationalized it as simply having been re-housed. Whilst acquiring stable accommodation is a necessary part of moving out of homelessness, research has shown it is not sufficient (e.g. Crane & Warnes, 2007; McNaughton, 2008). No studies were identified that endeavoured to explore the escape experience of participants who were more re-integrated into society. By recruiting participants who were merely re-housed, previous studies

may have set the bar too low in terms of selection criteria, resulting in a limited understanding of what is involved in escaping from homelessness.

This research sets out to explore the experience of those who are further on in their escape from homelessness than participants in previous studies. It aims to provide a greater understanding of what this escape involves and what helps the homeless to make it. By focusing on those who are ‘more escaped’, this study hopes to contribute to the limited knowledge base on what making a lasting escape from homelessness involves. Inspired by positive psychology (Seligman & Csikszentmihalyi, 2000), this study has focused on what works for those escaping homelessness, rather than what has gone wrong, as this will be of more use to those working with homeless populations.

1.3 Methodology

1.3.1 Participants

The population of interest for this study was people who had been homeless, but who were now 'escaped' from homelessness. Individuals were considered to have *been* homeless if they had previously 'sofa surfed'[1], lived in hostels or overnight shelters or slept rough[2] for a continuous period of at least four weeks. Having *escaped* from homelessness was operationalized as having lived in stable/long-term accommodation for at least six months and meeting the following conditions:

- Not abusing alcohol or any illicit substance;
- In paid work or further/higher education for most of the working day.

As interpretative phenomenological analysis (IPA; Smith, 1995) was chosen to analyse the data, participants needed to form a homogenous group in terms of their perspective on the phenomenon under consideration (Smith, Flowers & Larkin, 2009). Age, gender and country of origin are key demographic variables in the experience of homelessness (Philippot, et al., 2007) and were used to define homogeneity here. As the 'typical' homeless person is a 40 year old man (Firdion & Marpsat, 2007; Leonori, et al., 2000; Muñoz & Vázquez, 1999), clinical utility and pragmatism were served by recruiting male participants, aged 25-65, who were born in the UK. Five participants were recruited (in line with advice from Smith *et al.* (2009), who argue that four to ten participant interviews allow a level of analysis appropriate for a clinical thesis) and their 'pen portraits'

[1] Stayed with friends, relatives or acquaintances, sleeping on their floor or sofa on a short-term basis.
[2] Slept rough on the streets.

are given in Table 1.1. Although participants ranged on some demographic variables, the sample was still sufficiently homogeneous, as evidenced by the fact that it was possible to draw out common themes from their escape narratives.

1.3.1.1 Recruitment

Participants were recruited through homeless hostels they were still in contact with, and other community organisations working with homeless people. Staff forwarded participant information sheets (see Appendix B) to potential participants or used them to discuss participation. Those interested were contacted and invited for interview.

1.3.2 Design and materials

1.3.2.1 Design

This study is concerned with exploring the lived experience of men who have 'escaped' from homelessness and the sense they make of this experience. In view of the exploratory and descriptive nature of the primary research question, a qualitative approach was taken. Qualitative methodology allows both the capture of the "richness of the themes" (Smith, 1995, p. 9) contained in individual narratives and also preserves the essence of the individual perspective on their experience (Bramley & Eatough, 2005).

IPA was chosen as the method of data analysis. IPA is phenomenological in the sense that it is concerned with the individual's subjective perception and account of the topic under investigation (Smith, Jarmon & Osborn, 1999), in this case the escape from homelessness. IPA's commitment to exploring how people "make

Pseudonym	History of homelessness	Homeless life
Tom 46	Tom became homeless aged 40, following the breakup of his marriage. He moved into his own flat, but as his drinking escalated and his depression worsened, he struggled to maintain his tenancy, and gave it up. Initially he sofa surfed, but soon tired of this and ended up sleeping rough, staying on the streets for around four years. Tom spent a further two years in hostels when he came off the streets. When interviewed Tom was 46, in full-time further education and had been living in his own place for seven months.	"I was fully committed to dying on the street, because I'd convinced myself this is, this is my life, this is the way it's going to end. And I didn't really do anything about it. I had, I had no … Well I hadn't got any self-respect, no … I just didn't care, I was numb inside. I had no feeling …"
Steven 27	Steven became homeless at 22, following a break-up with his fiancée. She left him with debts that he was unable to manage and he was evicted. Steven's mental health is likely to have played a part here - he has recently been diagnosed with bipolar disorder. Steven was homeless for a total of 1½ years, sofa surfing and moving every two to three months. Steven has never slept rough or used a hostel. When interviewed Steven was 27, had been working in his current job for three years and had just moved into his own studio flat, having lived in shared accommodation for the last three years.	"It was difficult, it was definitely difficult erm constantly having to make adjustments in your life style of that kind of size was always a challenge and there was always, obviously the fear that I'd end up with nowhere and it would have to be the street."
Andrew 29	Andrew had been homeless before, but this period began when, aged 26, he left Scotland and moved to the West Midlands. Andrew talked about being 'frustrated' and feeling 'trapped' in Scotland, but not depressed. Initially he stayed with his girlfriend and her mother, but soon found himself in a hostel. He lived in hostels for a total of two years. Andrew had never slept rough. At the time of the interview, Andrew was 29, had been working at his current job for six months and lived in his flat for the same length of time.	"At the end, I was really starting to run out of patience because I was thinking, "Two years of my life I've been homeless". Two years is a, depending on how you look at it, can be a very short time, or a very long time. And I was actually close to going back to Scotland, very, very close."
Adam 33	Adam first became homeless around the age of 19, when his drug use became too chaotic for his parents to cope with. He had five or six periods of homelessness between the ages of 19 and 28, and estimates that he was homeless for a total of 3½ years, not counting time in prison. Adam had slept rough, used night shelters and hostels, sofa surfed and lived in squats. When interviewed, Adam was 33 and had been living in his current accommodation for 1½ years. He had been working in his current job for two years. He had last been homeless 4 ½ years ago.	"I was sort of quite content with faeces and dirty condoms and needles and everything else around me whilst I got warm with dirty old blanket and newspapers and I was …. I accepted that that's my life and that was the way I was going to be."
John 34	John first became homeless aged 14, when his mother expelled him from the family home because of his increasing criminal activity. John then began a cycle of moving between friends' houses, the streets (where he started using heroin) and then prison. John had slept rough, sofa surfed and used hostels and night shelters. When interviewed John was 34, had been living in his current accommodation for the last ten months and been working full-time for the last five months.	"I started getting locked up, and I come out, put into a hostel. And I was drugs, I was drug-free when I got out, I felt brilliant and then, no matter what hostel I went into, they was drugs. And I thought, 'Is this the cycle of life that's happened for me? Crime, drugs, hostel, prison, crime …'"

Table 1.1 Pen portraits of the participant

sense of their major life experiences" (Smith et al, 2009, p. 1) fits in well with this study's research question.

In addition, IPA's focus on the individual case is in line with the aim of this research: to improve understanding of how homeless *individuals* (in this case men) have escaped from homelessness. IPA is well-suited to studies such as this, concerned with the in-depth study of small numbers of individuals, as it permits "fine-grained and contextual analysis of the phenomenon under investigation" (Bramley & Eatough, 2005, p. 225) and allows the researcher to get "experience-close" (Smith et al, 2009, p. 33).

1.3.2.2 Materials

A semi-structured interview format was used (see Appendix C). This allowed greater flexibility than a conventional structured interview, enabling the researcher to follow up interesting emergent themes and the respondent to address the topic in ways most meaningful to them (Smith, 1995). Questions were designed to explore participants' experience of homelessness, focussing on their escape. Following the model of the narrative interview (Bauer, 1996), questions were grouped chronologically to cover:

- The route into homelessness;
- The experience of becoming and being homeless;
- The route out of homelessness;
- Life post-homelessness.

NVivo 8 qualitative data analysis software was used to facilitate the analysis.

1.3.3 Procedure

One-off in-depth interviews were carried out at participants' place of preference. Mean interview length was 71 minutes (range 65 - 79 minutes), suggesting that participants engaged well with interview questions and provided detailed accounts of their homeless experiences.

Participants were given information on the study (see Appendix B) and the opportunity to ask questions about their participation. Participants were then asked to sign a consent form (see Appendix D) to verify that they had understood the voluntary nature of participation, their rights regarding anonymity and withdrawing their data, and details of the complaints procedure. Explicit consent to be recorded was also obtained.

Interviews were recorded on a digital audio recorder and transcribed verbatim. Participants were given a pseudonym and all personally identifiable material was removed to ensure anonymity. Demographic information (see Appendix E) was collected at the end of the interview.

Participants were debriefed (see Appendix F) and given information on support services available if they wanted to pursue anything covered in the interview.

1.3.4 Analysis

Following transcription, the data was analysed using IPA, following the steps suggested by Smith *et al.* (2009). In line with the idiographic ethos of the research, interviews were analysed individually, before integrating the analysis across cases. The initial analysis was carried out by hand, as this allowed a more intimate and 'messy' involvement with the data. Transcripts were read through a

number of times and notes of anything appearing interesting or important were made in the right-hand margin (see Appendix G for example).

Higher-level themes were identified during subsequent readings and used to code transcripts. These emergent themes were then clustered under appropriate super-ordinate conceptual headings. This level of analysis was carried out using computer software, allowing for finer data-coding and greater flexibility in re-coding data and grouping/re-grouping themes than a 'pen and paper' approach (see Appendix H for example). On completing analysis for each transcript, tables of super-ordinate and sub-ordinate themes, along with illustrative excerpts for each, were produced (see Appendix I for example).

This process was repeated for all the transcripts, leading to a table of super-ordinate themes for each case. A master list of super-ordinate themes was then drawn up, incorporating all the themes raised in the individual interviews.

IPA has no pretensions to objectivity, but takes quality seriously (Smith et al, 2009), and the validity of interpretations was monitored in supervision. Both researcher and supervisor made exploratory notes and comments for sections of the first interview and these were compared and discussed. Full coding tables for each transcript, showing the detail of super-ordinate and sub-ordinate themes and excerpts which illustrated them, were also discussed in supervision. Early drafts of the results section were forwarded along with the NVivo database used to code the interviews.

A reflexive diary was kept throughout the study and served different functions at different stages. In the interview stage it was used to record impressions of participants and initial thoughts about themes covered in the interviews. During

transcription and analysis it was used to allow further exploration of, and reflection on, emerging themes.

1.3.5 Ethics

This study was conducted within the ethical framework provided by the codes of ethics and conduct of both Coventry University and the British Psychological Society.

During the proposal phase, this study was formally reviewed by staff on the Doctorate in Clinical Psychology programme at Coventry and Warwick universities. Feedback was also received from staff with experience in qualitative research, research and development in the NHS and clinical work with a homeless population.

Ethical approval for this research was sought and given from Coventry University Applied Research Committee (Appendix J). In addition, ethical clearance was also obtained from the various community organisations through which participants were recruited.

1.4 Results

The themes identified were: *life breaking in, decision to change, bad past* and *good present, better future.* The first two were associated with the escape from homelessness and the latter two with maintaining that escape.

1.4.1 Life breaking in

1.4.1.1 Low points

The experiences of most of the participants, around the time that they made their first steps towards escaping homelessness, can be framed in terms of them reaching a low point in their lives. There were differences though, and the most dramatic experiences were those of Tom and Adam who felt that they had come to the end of their lives. For Tom, his low point occurred when his alcohol abuse led to such a deterioration in his physical health that he was admitted to hospital after collapsing on the street, just days from dying.

> And I, my body... I remember falling actually, and I thought, “Here we go, this is it now. It's all over”, because I was fitting anyway, I was convulsing, I'd had them a couple of weeks prior to that …

Adam described his low point as the feeling that he had come to the end of himself, when he had reached the stage where he did not feel that the drugs were working for him any longer. Although his physical health at this time was poor, he defined his low point more in terms of its emotional and cognitive aspects.

> …the errm booze and the drugs stopped working. They stopped working, they stopped taking the pain away, they stopped taking the guilt away, they stopped taking the confusion in the mind. They stopped doing all of that, cos it was all there when I used.

While Steven and Andrew do not seem to have reached these depths, there was still evidence that the time their lives began to change was experienced as a low point. Steven had been dismissed by the organisation he had worked with voluntarily for over 18 months, and was left with the feeling that he had nothing to show for his time there.

> …it fell through and they errm told me I couldn't work up there any more and that I'd have to go back. And they said, "Right basically, you're fired, Can't do that here any more. Go home."

For Andrew, his low point was the state that he had reached at the end of his time in his first hostel, and the shock of being evicted and having to find somewhere else to stay.

> And I was drinking more in the end as well, at the end of that first one. Because I started thinking more negative which was leading me to drink more, which was leading to think more negative. I was getting trapped in a kind of ….. a wee negative hole somewhere.

John did not seem to experience the time before his move out of homelessness as an especially low point in his life, although he did talk about the sudden death of his partner, while he was in jail, and the subsequent loss of his son, who was taken away by her parents.

> So that's a kick up the arse as well, her passing away. So young, 33.
>
> …my son got taken away from me. Her Mum took my son to Ireland. And I ain't seen him since, he's nine now.

However, these by themselves were not enough to bring about change in his life and John resumed his heroin use within weeks of his release from prison.

It was not just negative events that were associated with the move out of homelessness: Tom and John both had experiences which they described in more positive terms. Tom was admitted to hospital following his collapse and was unconscious for some time; during this time he heard a voice.

> I kept on hearing someone telling to me, saying to me, that um, "You're not dead Tom, just get up. It's time to get up now. You're not dead Tom, it's time to get up now. Stop this now, it's time to get up." And …..ummm I don't know what it was inside me, and everything just …. it made me get up really.

Tom returned to his experience of the voice a number of times during the course of the interview and while he still puzzled about its source, it seems clear that it had a major impact on his decision not to drink any more.

> Yeah. Yeah but …..well …. I am trying to think, was it, was it one of the nurses but … no. But, it, it ...and, but... the strange thing is, I knew when I left hospital, I wasn't going to drink …

John's significant experience was a talk that he had with his father, some time after he had left prison. On his release from prison, John's father had invited John to stay with him, but when he resumed his heroin use his father had told him to leave. One day John's father invited him round and told him that he needed to grow up, that he was too old for this lifestyle and that he had his son to think about. This talk had a major impact on John and he described it thus:

> It just hit, he hit home. Everything he said hit home. I said I had to walk out, I walked out cos I knew he was right. It was, I was hurt, truth hurts don't it? And it hurt me, really did hurt me. [pause] So I was glad…

In a way reminiscent of the impact that the voice had on Tom, John's father's talk stayed with him on his return to the 'crack house' where he was living.

> Woke me up. And I was sat, I was sat in house, I kept think, I was in my head, I was hearing, I was hearing him saying it, over and over again.

1.4.1.2 Relationships

One of the clearest examples of others' impact on escaping from homelessness comes from Adam, who was helped by an organisation working with people on their release from prison. This support began before Adam reached his low point and has stayed with him. What seemed important for Adam was both what they did for him and that they stayed with him through his ups and downs, when his family felt unable to maintain contact.

> …they never give up on me: always phoning me, always wanting me to keep in touch with them. Umm it just, when it, I felt that the whole world had give up on me, these people didn't.

Adam had experienced people trying to help him before, but they had not been able to stay with him through the inevitable relapses in his drug use. The fact that this organisation did not give up on his was especially significant.

> It had a massive effect. You know, "These people weren't willing to give up on me, so why am I giving up?" You know what I mean? "Why am I giving up?"

Tom also talked about the support that he had from one of the hostels that he lived in after he left hospital. Previously Tom had talked about a loss of desire, a loss of vision and a giving up on himself, but as he experienced the help and concern of the staff at this hostel, he started to change.

> It's just finding the … people like who do a genuine job and it's, start to give you that belief back in yourself …. It gives you that belief back, it gives you that … respect back … err it helps you think ahead... It helps you cope with rejection and things, you know, a lot better.

For Andrew, his main experience of support came from the staff at the second hostel he lived in, following his eviction from the first one. Whilst he had found the staff at the first hostel unhelpful, overly analytic and inquisitive, he experienced the atmosphere at the second hostel as being entirely different.

> Like with the staff. Cos they would sit down and speak to you and say, "Is there anything that you want to talk about?" and things like that. And they were kind of open for discussion and that and they didnae treat like as any different.

Andrew felt that this friendlier attitude had a positive impact on him, and he too talked about a return of hope.

> It gave me new hope. ….. New hope, is it new hope you could call it, or better hope? Better expectations….

Although he does not explicitly make this link, it seems likely that this renewed hope was important in helping Andrew to pursue the housing and the job opportunity which led to his move out of the hostel after another year there.

For John, the support of his father on his release from prison appears to have been highly significant. It was the first time that John had felt supported by his family on release from prison, and the fact that it was his father offering him help seems to have been especially important.

> This time I got help. This time I got help, cos when I got out I went to my Dad's house. When I got released, I never had, I never had family support around me

> before, never had family support.

Although John's father asked him to leave when he started using heroin again, he maintained contact with John, letting him shower at the house and letting John's girlfriend stay with him. It was in this context of not shutting the door on John, that John's father called him over to have the talk that was to prove so significant for him.

Steven's experience of support around this time was quite different. Whilst homeless he had worked voluntarily and, although he had not felt especially supported by the organisation, the opportunities that they gave him played a significant part in his later escape from homelessness. He was given many responsibilities and the 'opportunity to excel' and, as he did so, this affected the way that he felt about himself:

> I discovered that I was much more capable than I'd given myself allowances for. Ermm so this time I suppose I knew that I could make a difference if I decided to ...because I was capable.

With his new confidence in his ability to affect his life, if he chose to, Steven was in a much better place to act when the organisation said that they could no longer allow him to work for them.

1.4.2 The decision to change

Following the experiences described above, participants seemed to have arrived at a clear decision point, experienced for some as a cross roads moment, where they had to choose between two very different future lives. For some, this decision process can be framed as a rejection of the homeless/drug-using life that

they were leading at the time and a positive statement of what they did want from their future lives. All but Andrew seem to have experienced this as a sudden process, even though the change that followed it was something that took place over a longer time period.

Tom realized that he had come to a choice between living and dying and that if he had carried on as he was then he would not still be alive.

> ... I just couldn't go any lower, that was the only way for me to get where I am today … I'd, you know, either be dead or go the other way I think, looking back on it.

Unlike others, who seemed to frame their decision in terms of a rejection of their past life style, Tom did not seem to do that. His decision seemed to take the form of a shift from the certainty that he was going to die on the streets as an alcoholic to the certainly that he was not going to drink any more.

> But then … I knew automatically then I would never drink again … And I don't know why that was … I knew I'd turned my life around …..

Adam too described his decision point as a cross roads moment, where he could choose between life and death and, when faced with this stark choice, chose life:

> I'd had enough. I'd had enough. I'd had enough of it. Cos I knew if I'd have carried on, I'd have been dead. And I didn't really want to die… in the end. I'd have been dead.

Adam then goes on to talk about his rejection of the life that he had been living up to that point, in terms of the things that he did not want:

> I didn't want to use and I didn't want to live on the streets and I didn't want to be homeless. I didn't want to hurt myself or anybody else.

John too talked in terms of having reached a life or death time in his life, although his situation does not seem to have been as desperate at that of Tom or Adam. During his last prison sentence, possibly precipitated by the death of his partner, he had started to reflect on his life:

> I thought, “Do you know what? I can’t do this no more. I’ll end up killing myself and having no life.”

John also reflected on the choice between life and death, following the talk he had with his father, when the need for him to grow up was raised.

> If I didn’t grow up, I wouldn’t be here now. I’d be in and out of jail. I’d still be smoking smack, and the crack, committing crime. I’d probably be on the streets, probably be dead. I don’t want that, I don’t want my life to end so young.

John's rejection of his drug-using lifestyle followed this talk and came as, surrounded by his drug-using friends, thinking about what his father had said and contemplating his father’s “four-bedroomed lovely warm bedroom house", he shouted:

> “What, where’s the heating, where’s the food? Nothing here! Cos it fucking, it’s a crack house, and I don’t want it no more!”

Whilst he did not frame his decision in life or death terms, Steven came to the realisation that he was faced with dealing with his situation or becoming homeless:

> …it was just me ermm and either I chose to deal with it or I gave in completely and I was on the street. Ermm and I was left with that choice really…

Steven's choice takes the form of a rejection of the status quo and a statement of the things that he wants from life:

> …it was a decision not to keep doing it any more, that I wanted … I wanted a stable income I wanted a job, I'd wanted – cos I'd worked since I left school, I didn't go to college – I wanted a job I wanted a house...

With Andrew, the decision point was less clearly stated. Although he acknowledged using a range of unhelpful ways of coping with his feelings in the first hostel, he did not say what changed on his move to the second hostel. The closest he got to talking about any changes came when he talked about what he learnt from his experience in the first hostel:

> Ermmm basically I learned from my mistakes from the first one and ermm I, also as well in the second one, like I say the staff were a lot more helpful.

1.4.3 Bad past

Adam gave the clearest illustration of the way in which being reminded of the past was helpful for him. For him, one of the main benefits of attending 12 Step meetings was the opportunity they provided to hear the stories of those who were early on in their recovery from addiction. These stories served to remind Adam where he had come from and what he could return to.

> …new-comers come and they share their experience and you hear them, and it just reminds me of what I don't want to go back to. So it's not only helping people, it helps me cos I'm reminded of what it can be like.

When asked specifically about things that were important in helping him maintain his life at the moment, he raised the theme of the past again.

> Not to forget where I've come from. Not to forget where I've come from.

Tom also talked about his relationship with the past, explaining how the memory of it had a positive effect, reminding him of where he had come from and giving him a focus for his current life. He was also still affected by it in a negative way, and the memory of it was difficult for him.

> I never want to go back to that … like the way I was, the way I was living … four or five years ago it was, it was just totally alien to me … Even though it creeps back up on me now and again – I still get depressed about it ….

Steven talked about the effect of the past in helping him keep on top of the routine aspects of daily life, things he often struggled with.

> … it's just making sure that things like that [rent], bills, Council Tax are – no matter what other priorities I have in my life – they are the top priorities. Because I don't want to end up there again.

Although the past was something that he clearly wished to avoid reliving, Steven seems to have believed that he needed to live through it, in order to achieve his current stability. In this sense, Steven seems to have viewed his homelessness, although unpleasant and difficult at times, as ultimately beneficial.

> …hard as it's been, I wouldn't change a thing. Ermm it's certainly been an experience errm and I've learnt a lot about it, a lot from it, ermm that's helping me now keep my life stable, and sort it out.

Andrew in general seemed less prepared than the other participants to reflect on the past. However, he too used the past as a motivation, something to avoid going back to, and as a way of helping him keep focussed on dealing with the more routine aspects of life.

> I'm focused on my work and my money and my flat and maintaining that. Not to go back to where I was before.

John's relationship with the past seemed to be somewhat different, although he too talked about a fear of going back, during a discussion on his need to keep busy:

> …don't want to be sitting around, a bum, on the J, Job Seekers. [unintelligible] I don't want to be a, I don't want to be a [unintelligible] for the rest of my life, I don't want it – it could lead to something else, to back where I was.

For the most part, in terms of his relationship with the past, John seemed more focussed on "getting back" the 15 years that he feels he had wasted when he was using heroin and living on the streets.

> I know I can't change the past, but I want to get them back. One way or another like I'm going good now. So them 15 years what I wasted, I can make sure I can have a good 15 years life.

1.4.4 Good present, better future

Tom talked about being happy with the life that he had at the time. This too seemed important – if life as it is, is not going well (even with its ups and downs) then the struggle to maintain escape will be that much more difficult.

> Life is pretty good, it still has its ups and downs , but, you know, you do, on the whole, you tend to manage … Errm …. well it's, I think the way it's … the way I want it to be ….

When asked about his plans to train as a counsellor, Tom talked about the way in which they were working to keep him focused on daily life and how they gave him something to work for.

> Excites me that does, I'm really looking forward to it …. And I, I'm not going to

> do anything to jeopardize that, you know ….But it, really, it excites me, I'm looking, I'm really looking forward to it

Here too is the implicit admission that he was still capable of returning to how things were, but that his hope for the future was so strong that he would not put it at risk by anything that he did in the present.

Steven also talked about the pull of the present and the way that life being so good now was a major factor in preventing any return to homelessness:

> …getting my own place, it's a sense of .. finally getting there, of that accomplishment and now I just have to keep it stable, which after all the work I've put into getting there in the first place, should be so much easier really [laughs].

Having realized his goal of getting his own place, after a long period of living in shared accommodation, Steven was focussed on maintaining it. There was a tension between the present, which he wanted to hold on to, and the past which he wanted to avoid reliving. For Steven, the fact that his present was so very positive means that it had a more powerful hold on him, serving to anchor him more effectively in his new way of life.

Andrew too was happy with his life at the time, although as he was not doing the job that he would really have liked to do. There were also difficulties in his relationships (including access to his son), and he was, understandably, more qualified in his remarks about his life than the others.

> I feel that my life's back on track, back to normal. Umm there's things that are, there's always room for improvement, isn't there?

There was almost a sense that Andrew had done what he needed to in getting the basics of life, of job and home, into place and was now able to look at what really motivated him. Andrew seemed to take less pleasure in the present, although he was happy enough with it, than the others, and was more motivated by the things that he was working towards – his other more creative interests, with the hope that one day he would be able to work in an area which really interested him.

> I want to be working in the media or sound industry, you know what I mean? And doing, cos I, doing what I would be really happy doing

Adam seemed more focussed on his achievements in the present, and he had achieved a lot: a self-employed carpenter, he was engaged to be married and had bought, and renovated, a house with his partner. It was almost as if he could not believe how well he had done and how far he had come:

> My… all… when I was in the treatment centre, my goals was to do voluntary work and get a sponsor and work the programme. And it's exceeded that.

When Adam talked about his present life, he focussed more on the negatives that were missing than the positives that were present:

> I've got nothing hanging over me, I've got no convictions hanging over me, they're all spent. I got no probation that I need to go and see. I've got no drug worker I need to go and see, you know what I mean?

Adam too had goals for the future, but he did not go into detail about these and they seemed less important for him. However, he was one of the few who talked

about personal goals, and this perhaps reflected his desire to hold onto what he had:

> I'm working on, or trying to get better at, not hitting the self-destruct button, self-sabotage. There's something, something within me that thinks, "Right. Everything's alright now, let's cause a bit of chaos."

John emphasized the pull that his current life had on him and how important it was in keeping him anchored in that life. When asked about what was important in helping him to maintain this life, he kept returning to his quality of life and his happiness with it.

> I'm just happy. I'm just.... I've got an amazing girlfriend, I've got... and my family are around me. I'm just happy. My job. I'm happy at it now, I'm …. I'm set for life now.

While very happy with his present, John thought about the future too and, of all participants, seemed to have the clearest picture of what he was looking forward to.

> You know it's going to be good. And then when I'm an old man, when I'm an old man, I got grand kids running round me, it's going to be brilliant. Looking forward to it as well.

1.5 Discussion

This study has explored the life-stories of five men who had experienced one or more forms of homelessness and no longer see themselves as homeless. These five men all had different routes into homelessness and different experiences of it. The study focuses on their experience of escaping from homelessness and the main themes that emerged clustered into two broad groups: those associated with escaping from homelessness and those associated with maintaining that escape.

In what follows, the main themes will be discussed in relation to the literature before considering clinical implications, limitations and recommendations for future research.

1.5.1 Exploration of themes

Life breaking in looked at how life events and relationships seemed to break into the cycles of homelessness and drug abuse participants were caught up in. Their combined effect seemed to be to bring participants to a 'turning point', after which time their lives went through a period of positive change. Some experienced this turning point as a low point, where physical and emotional resources were exhausted and their health was in jeopardy, or where plans had fallen apart and there seemed to be no way forward. Two of the participants had highly emotionally charged experiences, not portrayed as negative, which were significant in bringing them to a turning point: Tom heard a voice while in hospital and John had a talk with his father. These experiences seemed to have had the quality of epiphanies and both returned to them a number of times during their interview. Patterson and Tweed (2009) also found that the low point played an important part in the escape from homelessness: their participants ranked

‘hitting rock bottom’ second only to obtaining housing in facilitating their escape. The role of life events in bringing individuals to a turning point is also discussed in the 'recovery from addiction' literature. There the turning point is seen as the stage beyond which the addict is not prepared to go (McIntosh & McKeganey, 2001) and some view it as an essential step in recovery (Bess, Janus, & Rifkin, 1972). There too, turning points are usually associated with a range of negative experiences including sudden deterioration in health or other significant losses (Stall & Biernacki, 1986). However, McIntosh and McKeganey (2001), in their study of recovery from addiction, also found that positive events such as a child’s birth or the beginning of a new relationship could bring participants to a turning point.

In addition to being influenced by life events, participants’ escape from homelessness was also affected by their relationships. The experience of help and support from others was different for different participants: for some it seemed to be especially significant before their turning point, for others it seemed to come after it. Whilst some experienced this support as being more relational – impacting on feelings of self-worth – elements of it were practical: building up skills and dealing with day-to-day problems, leading to a greater sense of self-efficacy. Granfield and Cloud (2001) highlight the importance of maintaining relationships in their study of untreated recovery from addiction. Their participants' relationships, although put under considerable strain, had not been stretched to the point of breaking and played an important part in their recovery. During their years on the streets, participants in the current study had exhausted the good will of family and friends, or just lost contact with them. For most, the help and support that was important in their escape from homelessness came

from those who had not been close to them. Using the concept of an ‘emotional economy’ (Clark, 1987), it is as if they had gone into overdraft in all the accounts in their close relationships and needed to turn to others that were still available.

The decision to change looked at participants' experience of the turning point as a clear decision not to carry on with their lives as they had been. For some, this was as stark as choosing between life and death, for others it was a choice between the life they were currently living and a better one. For a number, this decision point took the form of a rejection of their homeless life and a positive statement of what they now wanted from life. There are similarities here with participants in McIntosh and McKeganey's (2001) study of recovery from addiction, one of whom describes his decision to change as being a crossroads in his life. Participants’ rejection of their homeless life can be conceptualized in terms of McIntosh and McKeganey's (2001) model of recovery from addiction in which the need to repair a broken identity is seen as central. From this perspective, the rejection of a homeless lifestyle is seen as the rejection of a homeless *identity*, which had become intolerable for the individual, and their positive statement a vision of a new identity.

Bad past explored the role of the past in the lives that participants were now living. While at times distressed by their memories of the past, participants used these reminders of ‘what it was like’ as a way of spurring themselves on with their current lives. In this way, the past functioned as a 'push', something to avoid returning to at all costs. This is similar to the finding, from the substance abuse literature, of the role played by the push from the negative consequences of a drug-using lifestyle plays in initiating recovery (Walters, 2000). However, in the current study, the push of the past seems to be functioning not to initiate, but to

maintain, escape from homelessness. Some also saw the past in a more positive light, as it had brought them to the good place that they were in at present. There are similarities here with the post-traumatic growth literature, where those who have suffered a range of traumas go on to experience positive growth (see e.g. Linley & Joseph, 2004 for a review).

Good present, better future looked at the way in which participants were, in general, happy with the life that they had at present – all had stable accommodation, a stable income - and had hope for the future. This happiness with their current lives exerted a strong pull on them, serving to anchor them in the present and preventing a return to their homeless lifestyles. Stall and Biernacki (1986) also found that quality of the current lifestyle played an important part in maintaining recovery from substance abuse. In their review, they identified management of a new identity and integration into a 'non-using' lifestyle as being the key mechanisms by which this occurred.

1.5.2 Clinical implications

This study reinforces the importance of timing when working with this population. Following a low point, homeless men (along with other groups) are likely to be more open to interventions - especially those for substance abuse - and these are more likely to be effective. While low points cannot be predicted with any certainty, targeting interventions at individuals on release from prison and on admission into hospital following health problems are two possible strategies.

For participants in this study, relationships played a key role in their escape from homelessness, but the long-term homeless are likely to have 'burnt their bridges'

with family and friends. Therefore, these relationships will often need to be supplied by the professionals working with the homeless. However, it is important that these professionals are genuine and open with their homeless 'clients' remembering that, above all else, they are people. Participants in this study told a number of stories of sub-standard help they had received, which was no help at all.

The quality of participants' present lives and their hope for the future played a crucial role in anchoring them in their new non-homeless lifestyle. Participants' jobs played an important part in this and it seems likely that, as McIntosh and McKeganey (2001) discuss, paid work has a key role in the process of 'social rehabilitation' which many ex-homeless will have to undergo if they are to escape homelessness. Re-entry into the job market thus needs to be a goal for those working with the homeless and they must be well-informed about local and national schemes available to help with this.

1.5.3 Limitations

Although this study used stricter criteria than previous research for operationalizing escape from homelessness, it was still not possible to determine whether participants had in fact managed this. Three of the participants had last been homeless less than a year ago and it is possible that they were still more *escaping* than *escaped*. Future research could target participants who had been homeless less recently and also consider conducting longitudinal follow-ups to establish continued escape.

This study has explored the experience of escaping from homelessness for just one group of participants: white men of working age, all of whom were homeless

in the same West Midlands city. Research has shown that age, gender and country of origin are key variables in the experience of homelessness (Philippot, et al., 2007); these variables are also likely to impact on the experience of escaping from homelessness. Further work needs to explore the experiences of different groups including women, children and young people, the elderly and those from other ethnic groups.

The number of participants in this study limited the extent to which the individual's experience of escaping from homelessness could be explored. Future research could consider working with smaller samples or single cases.

1.5.4 Future research

This research has been exploratory and sometimes quite descriptive in nature. Future research would benefit from looking in more detail at some of the changes that the homeless experience during their escape, with the aim of understanding more the underlying processes. This study did not arrive at a full understanding of what had changed to allow this escape to take place. However, McIntosh and McKeganey's (2001) conceptualization of the escape from addiction as an attempt to repair a broken identity seems to hold promise for the field of homelessness and merits further investigation.

For these men, their escape from homelessness seems to have resulted from a complex mix of external and internal events in the context of sustained and supportive relationships. This strong sense of relationships – and the relational self – together with the change process over time warrants further exploration. Conceptualizing escape from homelessness in terms of identity change may therefore be a promising area for future research.

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Chapter 2: Literature Review

The Effectiveness of Therapeutic Communities for Dually Diagnosed Homeless: A systematic review

Target Journal: ***Journal of Dual Diagnosis***

See Appendix K for Author Instructions

Word count (excluding tables, figures and reference list): 5923

2.1 Abstract

Objective

There is little agreement on which interventions work best for the homeless. The primary goal of this systematic review is to assess the effectiveness of therapeutic communities (TCs) as an intervention for the homeless dually diagnosed.

Methods

PsycINFO, Web of Science, ASSIA and PubMed were searched for all dates until December 2010 using the following terms: therapy, therapeutic, community, homeless, homelessness, effective(ness), efficacy, outcome, evaluate, evaluation. Citation and reference list searches of key articles were also carried out. 113 unique articles were retrieved and 37 underwent full review. Ten articles met inclusion criteria (evaluation of therapeutic community intervention for homeless dually diagnosed patients).

Results

TCs with adaptations for patients with mental illness, in addition to substance dependency, led to small improvements in substance abuse, mental health and housing outcomes. However, these effects were short-lived and most were not present after a year. There was no conclusive evidence that one type of TC was more effective than any other.

Conclusions

This review has found little conclusive evidence in support of TCs as effective in treating a range of patients with dual diagnoses. However, the limitations of the studies reviewed mean that any conclusions drawn from their findings must be tentative. Homelessness in general is under-researched and more attention needs to be given to what interventions would best serve those who find themselves in this desperate state.

Key words: dual diagnosis, homeless, therapeutic community

2.2 Introduction

2.2.1 Causes of homelessness

Homelessness is a complex phenomenon, arising from interactions between a range of socioeconomic and personal vulnerability factors including: housing policy, unemployment, social welfare policy and immigration, the breakdown of social networks, addiction and loneliness, physical and mental illness, and traumatic life events (Philippot, Lecocq, Sempoux, Nachtergael & Galand, 2007). Research into the prevalence of mental health problems amongst the homeless has found very high rates, ranging from 58% to 100% (Philippot, et al., 2007), and there is an especially high prevalence of substance abuse and dependence, particularly of alcohol. Studies looking at whether substance abuse has preceded or followed homelessness have found that, for most homeless individuals, these problems were present before they became homeless (Muñoz, Koegel, Vázquez, Sanz, & Burnam, 2002). A number of authors have also found high levels of stressful events in the lives of homeless individuals, strongly linked with mental health problems, often preceding the onset of their homelessness (Muñoz, Vázquez, Bermejo & Vázquez, 1999), and high rates of post-traumatic stress disorder (Philippot, et al., 2007; Taylor & Sharpe, 2008). In addition, studies have found high rates of co-existing mental health and substance misuse problems, so-called ‘dual diagnosis’, among groups of homeless people (DoH, 2002).

2.2.2 Services for the dually diagnosed

A significant number of homeless have both mental health and substance abuse problems, and evidence points to these factors having a causal role in their

homelessness. This suggests that effective treatments for this vulnerable population will need to combine mental health and substance abuse services. Research evaluating different approaches to combining treatments suggests that the integrated model, where simultaneous care is provided for both conditions by the same staff member or clinical team, is the most effective for this client group (DoH, 2002). However, mental health and substance abuse treatment services have traditionally grown up, and been run, separately with little or no integration. Patients have tended to be treated in one system or the other, with some left shuttling between the two, or falling between the gaps and not receiving treatment from either. Currently, there are still few services providing treatment explicitly for patients with dual diagnoses in England and a report by the Care Service Improvement Partnership (CSIP, 2007) found that many local implementation teams had not agreed a dual diagnosis strategy with local stakeholders. Interventions targeted at dually diagnosed patients, who are also homeless, need to address the additional needs of this group as the “basic priorities of safety and protection” (Drake, Osher, & Wallach, 1991) are unlikely to be met while patients are sleeping rough or living in hostels or over-night shelters.

2.2.3 Therapeutic communities

One model of integrated treatment which holds the potential to meet the needs of this group is the *therapeutic community* (TC). TCs are based on *milieu therapy* (Jones, 1953) where treatment is viewed as the normal interactions of healthy community life. In this model, the community of both staff and patients plays a key role in patients' recovery. Patients gain emotional support from both staff and each other and, alongside staff, play an active role in the community with 'real'

jobs to do and genuine participation in decision making. The term *therapeutic community* originated in the UK to describe units based on the social recovery model for patients previously treated in locked psychiatric wards. TCs in the UK are currently found in a range of settings and work with patients with a range of needs including: learning disabilities, personality disorders, forensic behaviours and addictions. However, in the USA, the term is more commonly used to describe an approach for the treatment of drug and alcohol addiction. McLaughlin and Pepper (1991) describe a TC as a highly structured programme with a planned stay of between 18-24 months. Treatment usually starts with a month long 'orientation phase' where the patient is orientated to the programme ethos, using a range of rewards and punishments. Rewards, usually taking the form of privileges, are earned for positive behaviours which are also reinforced by praise from the whole community. Behaviour seen as negative, can lead to a range of sanctions and is also raised at the frequent house meetings, sometimes in quite confrontational ways.

2.2.3.1 Modified TCs

TCs set high levels of expectations, which patients with severe mental health problems can struggle to meet. This is acknowledged in the movement to modify TCs to make them more accessible to dually diagnosed patients. A range of modifications have been described in the literature, including: providing access to psychiatric services, integrating mental health with drug abuse teams and expanding the educational programme to incorporate psycho-educational groups and elements of the less harsh Twelve-Step programme. The system of rewards and punishments has also been reviewed, with a greater emphasis on rewards and less confrontation. Even the core ethos of community participation has been

affected: whilst some communities permit some flexibility in the demands placed on individual patients, others have reduced the level for all - outsourcing key roles such as meal preparation. More recently, some TCs have attempted to take into account the cognitive demands of the intervention, by making treatment groups shorter and presenting information at a slower pace.

2.2.4 Reviews of effectiveness of TCs

2.2.4.1 TCs for substance abuse and dual diagnoses

No systematic reviews of the effectiveness of TCs for patients with dual diagnoses were found. However, Smith, Gates and Foxcroft (2008) carried out a *Cochrane Review* of their effectiveness for the treatment of substance abuse disorders. Their review, limited to randomised controlled trials (RCTs) only, found little evidence that TCs provided better outcomes than other residential programmes, or that one type of TC was more effective than another. However, they conceded that firm conclusions could not be drawn due to the limitations of the existing evidence. In a wide-ranging review of all interventions aimed at improving the health of the homeless, Hwang, Tolomiczenko, Kouyoumdjian and Garner (2005) briefly touched on TCs for the dually diagnosed. Reviewing three RCTs, they concluded that TCs had little effect, leading to lower depression scores but having no impact on other psychological symptoms, substance abuse or HIV risk behaviours. Sacks, McKendrick, Sacks and Cleland (2010) found differently in their meta-analysis of three studies of modified TCs (MTCs) for various groups of patients with dual diagnoses. They reported moderate treatment effects for substance abuse, mental health, crime, employment and housing outcomes; only HIV risk behaviours were unimproved.

2.2.4.2 Residential interventions for dual diagnoses

Reviews of a broader range of psychosocial interventions for those with dual diagnoses have been more common, and some of these have included residential programmes. One of the most recent is by Cleary, Hunt, Matheson and Walter (2009) who reviewed a total of 54 studies evaluating the efficacy of a range of interventions for those with dual diagnoses. Only some of their residential programmes were TCs, and they included studies with both homeless and non-homeless populations. They found some support for the effectiveness of long-term residential programmes with dually diagnosed patients, but the evidence for this was of lower quality than for other interventions. An earlier review by Drake, O'Neal and Wallach (2008) had similar findings for long-term residential programmes, and they too bemoaned the quality of the evidence. Brunette, Mueser and Drake (2004) targeted their efficacy review only on residential programmes for those with dual diagnoses. They reviewed a total of ten studies, evaluating both TCs and other residential programmes, with participants both homeless and non-homeless. They found evidence that programmes with good integration of mental health and substance abuse approaches could be effective for patients with dual diagnoses. Their findings also suggested that programmes should be flexible, more supportive, of lower intensity and longer-term.

TCs remain a popular intervention for the treatment of patients with dual diagnoses, especially in the United States and across Europe (Smith, Gates & Foxcroft, 2008), yet there have been few studies which have looked at their effectiveness for treating homeless people with dual diagnoses. Despite the paucity of the evidence, strong claims for the effectiveness of TCs in the treatment of patients with substance abuse continue to be made. Young (2010)

further makes the case for TCs as effective for patients with a wider range of issues, including mental health, homelessness and criminality. Before expanding the use of TCs to include patients with more complex needs, or embarking on further research to assess their effectiveness, it is important to make sense of the emerging evidence.

The main aim of this paper is to systematically review and summarise the evidence from all studies evaluating the effectiveness of TCs for the treatment of homeless patients with dual diagnoses. This information will be useful to those responsible for planning and providing services for this vulnerable patient group. The secondary aim of this article is to assess the quality of the research reviewed and make recommendations for future work.

2.3 Method

2.3.1 Search strategy

A systematic search was conducted in December 2010, using the following electronic databases, for all records up until the present time: PsycINFO, Web of Science, ASSIA and PubMed. A search was also carried out on Google Scholar. PubMed was searched using the MeSH headings *homeless* and *therapeutic community*. Combinations of the following search terms were used for the others: *therap*, communit*, homeless*, effective*, efficacy, evaluate*, outcome* (where * indicates the wildcard operator).

Records were imported into EndNote version X3 reference management software, and duplicates excluded, using EndNote's *Find duplicates* function and then by a manual title and author sort. An initial eligibility sort was carried out using article titles and abstracts. Full-text copies of all potentially suitable articles were then reviewed to determine whether they met inclusion criteria.

Citation searches were carried out for all studies included in the review, using the Web of Science *Cited reference search* function. A reference search was also carried out for all selected articles, using their published reference lists.

2.3.2 Study selection

Studies were included in this review if they took the form of an evaluation of the effectiveness of a TC for the dually diagnosed homeless. All studies were included which involved interventions labelled as TCs, or described in such a way that it was clear that they were. This included some studies where the TC was used as the comparison group. A broad spectrum of TCs was reviewed,

varying in length, in setting, in degree of adaptation to the needs of patients with mental health problems and in purity of doctrine. However, all subscribed to the same ethos of 'community as method' and had made some effort to accommodate patients' mental health needs. Qualitative studies were in principle included, but purely descriptive studies were not. This review aimed to include studies with a wide range of methodologies – experimental, quasi-experimental and pre/post-evaluations – acknowledging that studies with less rigorous designs can still provide useful and reliable information (Howland, 2007).

2.3.3 Systematic search results

The initial searches resulted in a total of 165 articles being retrieved. After duplicates were removed, a total of 113 unique articles remained. These were initially reviewed by title and abstract, leading to the exclusion of 75 articles that did not involve therapeutic communities, dealt with physical health interventions or were not intervention studies. A further two studies were excluded at this stage because there were only available as dissertation abstracts. The remaining 36 articles were evaluated in full and of these 26 were excluded because they did not involve therapeutic communities, were descriptions of interventions or did not study a homeless dually diagnosed population. This left 10 unique studies for which citation searches and reference list searches were conducted. Neither of these strategies resulted in additional unique studies. Figure 2.1 illustrates this process.

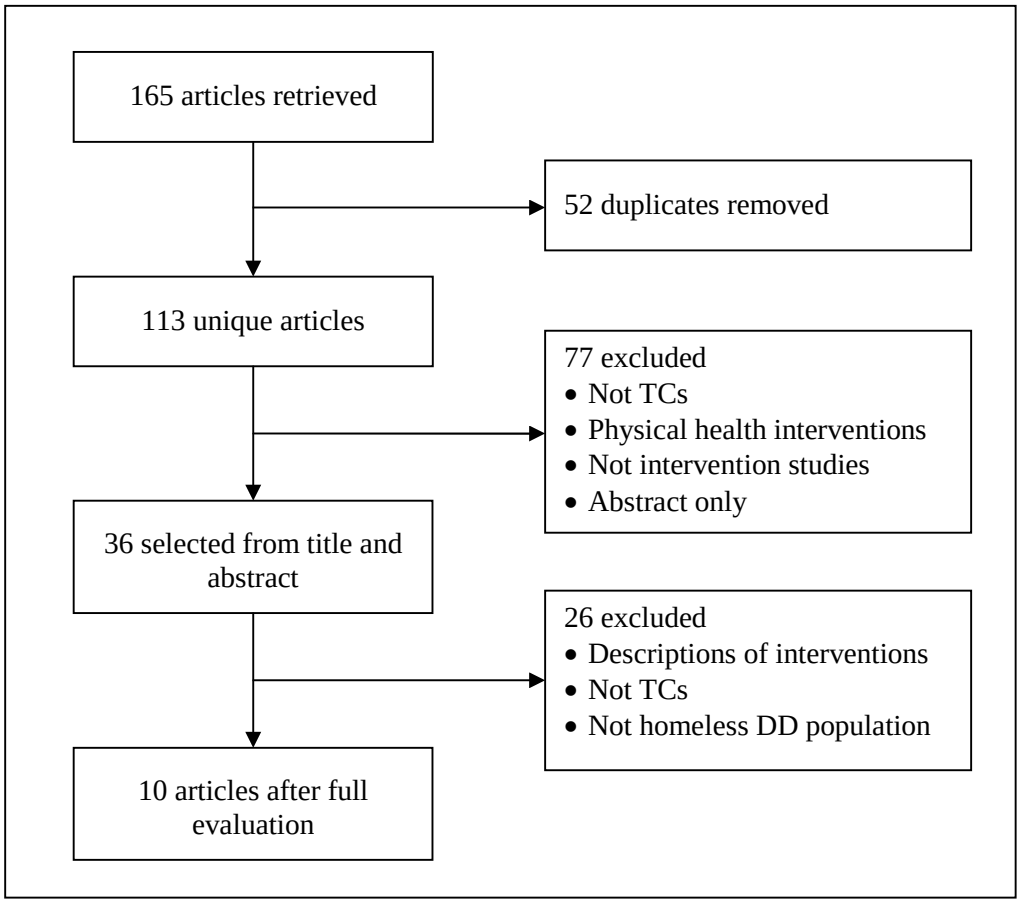

Figure 2.1. Summary of systematic selection process

2.4 Results

The ten studies included in the review were all carried out in the USA: seven in New York City, and one each in Philadelphia, Los Angeles and Dallas. All participants were homeless and had diagnoses of both mental health and substance abuse disorders. Participants were mainly men, with six of the studies having men only and the remaining four ranging between 63-84% men. The mean age of participants ranged from 31 to 50 years old, but for most studies mean age was in the 30s. The mean years of education was 12 or under in all of the studies. Most studies had a majority of African American participants, ranging from 56-77%, with the remainder being Caucasian or Hispanic. However, in two of the studies there was a majority of Caucasian participants.

The interventions, too, varied on a number of dimensions. On length, they ranged between three months and two years; three of the studies did not clarify the length of the intervention. Their settings varied between purpose-built facilities, wards of general hospitals and wings of general shelters. Lastly, interventions also varied on the extent to which they had been adapted from traditional drug treatment TCs to take into account the needs of patients with additional mental health problems. While some interventions were described more thoroughly than others, they can still be clustered into three broad groups in terms of their degree of adaptation:

i. Those with mental health services 'bolted on';

ii. Those with a greater integration of mental health and substance abuse treatment;

iii. Those with additional adaptations to reduce the cognitive demands of the programme.

TCs in the first group have kept their basic ethos, but have included extra services to enable patients with severe mental health problems to access them. The second group contained TCs with a greater level of modification, including some acknowledgement that people with severe mental health problems benefit from a more flexible approach. There was also generally less confrontation, with fewer sanctions and more rewards. The third group contained TCs with the highest level of modifications, based on the MTC (Sacks, De Leon, Bernhardt, & Sacks, 1997) model . They included additional modifications to take into account the cognitive demands of the intervention, e.g. shorter treatment groups and information presented at a slower pace.

2.4.1 Study quality

Table 2.1, based on the format used by Altena, Brilleslijper-Kater and Wolf (2010), provides an overview of key variables considered important for determining the quality of the studies reviewed. In an attempt to improve objectivity, where possible numerical values, or simple 'Yes/No' answers have been provided; where not possible, variables have been rated as 'good', 'fair' or 'poor'. There was considerable variability in the quality of the descriptions of the TCs, with some studies giving only general descriptions of TCs and others stating only that the intervention was a TC. Given that a TC is not a closely-defined intervention, the lack of detail in some studies made it difficult to know in practice what the intervention involved. Study design was a particular weakness for the studies reviewed, with only two achieving full randomisation

	Anderson (1999)	Blankertz (1994)	Burnam (1995)	De Leon (2000)	Egelko (2002)	Liberty (1998)	McCracken (2005)	Nuttbrock (1998)	Rahav (1995)	Skinner (2005)
Description of intervention(s)	Fair	Good	Good	Fair	Fair	Fair	Good	Fair	Poor	Poor
Control	TC control	TC control	TAU	TAU	No	C&S	No	2 CRs	4 CRs	Shelter
Random allocation	Time window review	Sequential allocation	Yes	Sequential allocation	N/a	Time window review	N/a	Sequential allocation	Yes	Time window review
Sample size	225	176	276	342	124	605	37	694	616	140
Study retention	Not clear	51%	70%	82%	35%	35%	Not reported	12%	17%	N/a
Initial similarity of groups	No	No	Yes	Yes	N/a	No	N/a	No	No	No
Maintenance of similar groups	N/a	N/a	Yes	Yes	N/a	N/a	N/a	N/a	N/a	N/a
Baseline measures	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Measurements (range)	Poor	Poor	Fair	Good	Fair	Good	Poor	Fair	Fair	Poor
Follow-up	3 m	3m	9m	9-18m	No	3-9m	No	No	No	No
ITT analysis	No	No	Yes	Yes	No	Yes	No	No	No	No
Statistics reporting	Fair	Fair	Good	Poor	Good	Good	Poor	Good	Fair	Poor
Clinical significance	N/a	N/a	No	No	No	Yes	No	No	No	No

Table 2.1. Summary of quality parameters for studies reviewed

and a further three using sequential allocation. The randomisation procedures impacted on the initial similarity of groups and only two studies managed to achieve this. Two of the studies were not controlled, with others using interventions (with a number of similar components) as comparison groups; only two used a treatment as usual (TAU) control. Sample sizes were generally good, with only one study having fewer than Hwang *et al.'s* (2005) quality target of 50 participants per group. However, as for most studies with this population, retention rates were poor with only one study achieving Hwang *et al.'s* (2005) 80% cut-off for studies rated 'good'. Follow-ups were another area of weakness, with five of the studies only assessing outcomes during the course of the intervention. Of those that did conduct follow-ups, only two followed up as far as nine months after the end of the programme.

Most studies relied on self-report measures, and while unavoidable for some outcomes, this approach can result in under-reporting rates of socially undesirable behaviour, such as criminality and substance abuse. Only three of the studies undertook intention-to-treat (ITT) analysis, where participants are followed through from allocation, even if they do not receive the intervention they were assigned to. Studies not following this protocol, run the risk of over-estimating the effect of the intervention in practice, as they only measure its impact on the subgroup of those who complete it. The reporting of statistical analysis varied in quality between the studies. The worst examples reported only mean values or significance levels (not both), or provided only verbal summaries of analyses, which it was then not possible to verify. Only one of the studies considered the clinical significance of the changes in outcome brought about by the intervention.

2.4.2 Outcome measures

Reduction in drug and alcohol use was a key aim for many of the studies, with all but one including some measure of substance abuse as one of their outcomes. The measures used ranged from urine toxicology, through structured instruments, to client self-report of number and frequency of drugs used.

Four of the studies measured outcomes only while participants were 'in programme'. These studies focussed on psychological outcomes - primarily anxiety and depression, but also social functioning and self-concept/self-esteem. However, two also used the Global Assessment of Functioning (GAF; APA, 2000) as a proxy for the ability to live independently in the community. The remaining studies measured outcome on discharge or at follow-up. Three of these measured a range of outcomes including: mental health (mainly anxiety and depression), criminality, HIV risk behaviours, and housing and employment status. The other three studies used binary measures of outcome, related to abstinence, discharge status and appropriateness of housing placement, with two of them using these outcomes to construct a composite measure of 'success'.

In general, insufficient consideration seems to have been given to the selection of measures used and there was little attempt to standardise choice of measure across studies even when outcomes were similar.

2.4.3 Study results

2.4.3.1 TCs with additional services

For both of the studies in this group, the TC acted as the comparison group. This may have resulted in it being described in less favourable terms, and seeming less adapted to the needs of patients with mental illnesses than it actually was.

Anderson (1999) compared outcomes for patients who were resident at an “integrated programme” approach, where the emphasis was on working with mental health and substance abuse issues in an “open, non threatening environment” with those for patients in a TC over the same time period. He found significant differences between groups at the three-month follow-up: the TC had higher drop-out rates and a lower percentage of patients 'successfully placed' (operationalized as GAF score of 80 or above). Substance abuse relapse rates were also higher in the TC, but re-hospitalisation rates were similar in both groups. However, the groups differed on a number of key demographic and drug-use variables and baseline measures were not reported, only outcomes at graduation and three-month follow-up. Consequently, it was difficult to establish with any reliability whether differences in outcome were due to differences in the interventions or initial differences in the populations.

Blankertz and Cnaan (1994) used a quasi-experimental design with sequential allocation to assign participants to its two conditions. Here the experimental group was a “hybrid psychosocial and drug rehabilitation programme” which emphasised the importance of individualisation and client choice. Patients who had stayed longer than 60 days in either programme were followed up at three months after leaving the programme. The experimental group had a significantly higher percentage of patients meeting criteria for successfully exiting at the three-month follow-up: i.e. abstinent from drugs and/or alcohol, no hospitalizations and living in permanent accommodation. Although differences in patient characteristics between the two programmes were reported, discriminant analyses indicated that these did not have a significant impact on outcome. Successful outcome was found to be best predicted by the number of

positive rewards patients received and participation in the experimental programme.

In summary, the tentative conclusion from these two studies is that the experimental interventions had more favourable outcomes than the more traditional TC, even with some adaptations for patients with severe mental health problems. The experimental interventions reviewed in these studies used a less confrontational, more supportive and flexible approach, which seems to have been more effective with this population.

2.4.3.2 TCs with more flexible approach

In an RCT, Burnam, Morton, McGlynn, Petersen, Stecher, Hayes *et al.* (1996) compared the effectiveness of two TC programmes (one residential and one non-residential) with a TAU condition where participants were free to access other community supports. Outcomes were measured at baseline and at three-, six- and nine-month follow-ups. Intervention attrition was high with 40% of those referred not attending either programme. Among those who did attend, retention was higher in the residential programme. The ITT analysis showed no significant differences between the two treatment groups, with both showing significant improvements in substance abuse, symptoms of depression and anxiety, self-esteem and housing status. However, the size of the improvements in depression, anxiety and self-esteem were small, with no evidence of improvements in measures of psychotic symptoms, mania or anger/hostility. When treatment conditions were combined, the only statistically significant improvement, compared to control, was a decrease in days of alcohol use at three-month follow-up; this was not present at six- or nine-month follow-ups. Regression

analysis indicated significant effects of exposure to treatment for substance abuse and housing outcomes, but these did not remain by the nine-month follow-up. When indicators of out-of-programme treatment were added to the regression model, exposure to treatment became significantly associated with improvements in some measures of mental health at three-month follow-up, but these too had evaporated by later follow-ups.

In an experimental study, Rahav, Rivera, Nuttbrock, Ng-Mak, Sturz, Link *et al.* (1995) compared outcomes for a TC with four community residences[1] (CRs) at baseline and after two, six and 12 months in the programme. Although participants were randomly assigned to the two conditions, there was a longer wait for admission to the CRs and a higher rate of attrition before admission. The longer wait may have acted as a barrier to those with more severe mental health problems, who were then over-represented in the TC. Once admitted, retention rates were higher at the CRs than the TC. Both conditions showed improvements in measures of psychotic ideation, level of functioning and self-esteem, but these were of greater magnitude in the TC. However, only the changes in functioning were of a magnitude likely to have been clinically significant. As mean values only were reported, with no significance levels for these comparisons, it was not possible to determine which of these differences were statistically significant. Regression analysis was conducted with two models, one in which the baseline differences in symptom severity between the TC and CR were controlled for. The TC was associated with small, but significant, improvements in depression and level of functioning (both models) and psychiatric symptoms (unadjusted model only). There were also non-significant trends for greater improvement in

[1] Community residences aim to provide a less restrictive alternative to acute inpatient settings for the treatment of mental health problems.

self-esteem (unadjusted model only) and psychotic ideation (adjusted model only) for the TC.

Nuttbrock, Rahav, Rivera, Ng-Mak and Link (1998) used a quasi-experimental design, with sequential allocation to conditions, to compare outcomes for patients referred to a TC with those referred to two CRs, which had been enhanced to provide treatment for mentally ill patients with co-occurring substance disorders. The CRs had a higher attrition rate before admission, but a lower attrition rate after admission than the TC. However, analysis indicated that neither homelessness, substance use, nor psychopathology were associated with attrition for either programme. Outcomes were measured at baseline and after two, six and 12 months in the programme. There were small improvements in depression, anxiety and psychiatric symptoms between all time points, but these were significant (with Bonferroni correction for multiple comparisons) only for the TC. There were also small improvements in level of functioning for both conditions, but significant for the CR only between baseline and 12 months. Changes in measures of agoraphobia and psychotic ideation were not significant for either condition. Self-reported drug use was lower in the TC at all times, but this was not significant with the Bonferroni correction. Regression analysis showed that treatment at the TC was associated with greater improvements in anxiety, psychiatric symptoms and level of functioning. However, these were only significant for anxiety and psychiatric symptoms at two months and for functioning at 12 months.

Liberty, Johnson, Jainchill, Ryder, Messina, Reynolds *et al.* (1998) compared outcomes (within staggered time frames) for two TCs within homeless shelters, with those for a ‘clean and sober’ (C&S) dormitory also in a homeless shelter.

This design resulted in non-similar groups, with participants in the C&S dormitory having lower baseline levels of crime, drug use, motivation for drug treatment and depression. Differences in demographic variables were also reported between the groups. The two TCs differed on a number of dimensions: TC_1 was only three months long, had meals brought in from outside and paid shelter staff were not a key part of the community. TC_2 more resembled a traditional TC with a greater emphasis on the community as the main agent of recovery. Retention rates varied between conditions and were highest at TC_2 and lowest at the C&S dormitory. At follow-up, three to six months after leaving treatment, patients in TC_1 showed a significant decline in substance abuse. However, logistic regression showed that length of time in treatment was a better predictor of reduction in substance abuse than programme attended. All three groups exhibited significant major decreases in depression, but regression analysis, controlling for baseline differences, demonstrated that neither time in treatment nor treatment group predicted these. There was also a small decrease in measures of hopelessness, but this was significant only for TC_1. There were significant reductions in levels of criminality across all groups, but these were not predicted by baseline illegal activity nor length of time in treatment. There were no significant changes in rates of homelessness or employment status for any group.

McCracken and Black (2005) carried out a pre/post-evaluation of a TC, comparing outcomes at baseline with those after six weeks, three months and six months in the programme. They found significant improvements in measures of interpersonal relatedness and social role at six months compared to baseline. They also reported early significant improvements in measures of general and

symptom distress, the presence of substance abuse disorder, and drug and alcohol use; these changes were no longer present at six months. However, as mean values were not reported, it was not possible to gain any indication of the magnitude of any of these changes.

In summary, it appears that the TCs reviewed in this section have brought about significant, but generally small, initial improvements in a range of outcomes including: substance abuse, criminality, housing status and a range of mental health symptoms including depression and anxiety. Improvements have also been noted in level of functioning and measures of self-esteem and social role interaction. Studies including comparisons of TCs have found similar outcomes for residential vs. non-residential and low demand vs. high demand. However, when outcomes have been compared to control, there have been few differences attributable to the TC intervention. In addition, improvements were often short-lived, some disappearing before the end of the intervention. Studies which have conducted follow-ups after the end of the programme have found that few differences remain, relative to baseline, at 12 months.

2.4.3.3 Modified TCs

De Leon, Sacks, Staines and McKendrick (2000) used a quasi-experimental design to compare outcomes for two therapeutic communities, TC_1 and TC_2 , with TAU. TC_2 had been further modified to have lower demands on patients and more staff guidance. Outcomes were measured at baseline, after 12 months in the programme and at last contact (time F: 9-18 months after the end of primary treatment). Bivariate analyses were conducted for outcomes at 12 months and time F. Verbal summaries of these analyses cited significant improvements at 12

months, for all conditions, in terms of drug use, criminality and anxiety; in addition, alcohol use was reduced in both TCs. TC_1 also showed improvements in self-esteem and TC_2 in levels of depression and HIV risk behaviours. Bivariate analysis at time F was reported as showing that the TCs improved on more variables than TAU.

Regression analysis showed significant improvements for TC_1, compared to TAU, in terms of employment status (12 months and time F) and criminality (time F). When TC_2 was compared with TAU, there were additional improvements in drug and alcohol use (12 months and time F) and depression and anxiety (time F). However, beta coefficients for these analyses were small, suggesting that the improvements, although statistically significant, were unlikely to be clinically significant. When the two therapeutic communities were compared, TC_2 was shown to have a significantly higher retention rate than TC_1. A regression analysis comparing the two was reported as showing that TC_2 had better outcomes in terms of retention, drug abuse and depression (12 months and time F), criminality (12 months) and anxiety (time F); details for this were however not reported.

Skinner (2005) compared outcomes for a TC in a shelter, with those in a general shelter, in a retrospective closed-case records review. The detail of the analysis for the whole sample was not provided, but he reported that those in the TC were less likely to be hospitalized or transferred to a higher level of care on discharge. He also reported higher rates of medication compliance and appropriateness of housing placement, to level of functioning, for the TC. However, there were no significant differences in length of sobriety, psychiatric hospitalizations since shelter entry, length of stay and housing placement status. When findings were

controlled for the fact that there were more ex-soldiers in the general shelter, the only significant difference between the two conditions was that medication compliance was higher in the general shelter.

Egelko, Galanter, Dermatis, Jurewicz, Jamison, Dingle *et al.* (2002) carried out a pre/post-evaluation to compare outcomes at baseline and six months for patients in a TC. They found small, but significant, reductions in depression, anxiety and an overall measure of psychiatric symptoms, between baseline and three months. The reduction in anxiety was retained at six months and there were further improvements in depression and psychiatric symptoms and also a small, but significant, improvement in self-esteem. Further analysis showed that improvement was not affected by the severity of mental illness, for which the number of past psychiatric admissions was used as a proxy.

The overall pattern here is similar to that in the previous section, with MTCs leading to small, but significant, improvements in drug use, criminality, HIV risk behaviours and psychological measures such as depression, anxiety and self-esteem. As before, when outcomes were compared to TAU, there were less significant differences. Where different MTC models were compared, it was found that the lower intensity one reported the better outcomes. Here too, improvements were short-lived and the only study which included a follow-up (De Leon, et al., 2000) found that by 18 months, differences compared to baseline were small indeed.

2.5 Discussion

This review has evaluated the effectiveness of TCs for the treatment of dually diagnosed homeless patients. A total of ten studies were reviewed: two RCTs, three quasi-experimental studies, three non-experimental studies and two uncontrolled pre/post evaluation studies. A consequence of the decision to include studies with a range of methodologies was that quality varied widely, creating difficulty when it came to interpreting some of their results.

2.5.1 Summary of findings

The overall finding was that TCs with a greater level of adaptation for patients with additional mental health problems, led to small improvements, compared to control, in substance abuse, mental health and housing outcomes. However, these effects were not long-lasting and most had disappeared within a year of leaving the programme. There was no evidence of any effect of setting, with non-residential TCs and TCs in other facilities faring no worse than those in dedicated premises. The findings for 'lower demand' TCs were mixed, with one study finding little difference compared to higher demand and another finding improvements in terms of retention rate and levels of drug abuse, criminality, depression and anxiety.

2.5.2 Discussion of findings

These findings are broadly in line with those from Smith *et al.'s* (2008) review of TCs for substance abuse disorders. They found that there was little evidence of TCs being more effective than other residential programmes or one type of TC having better outcomes than another. Hwang *et al.'s* (2005) review of all health oriented interventions for the homeless had a similar finding, although they

found some evidence for lower depression scores in TCs. Other reviews of interventions for patients with dual diagnoses have found more positive outcomes for residential programmes, including therapeutic communities. Both Cleary *et al.* (2009) and Drake *et al.* (2008) found some support for the effectiveness of long-term residential programmes for this group. Similarly Brunette *et al.* (2004) found evidence for the effectiveness of residential programmes (including TCs) which integrated mental health and substance abuse treatment. They also found better outcomes for programmes which were more flexible, more supportive, of lower intensity and longer-term.

The quality of the studies reviewed varied widely: a key difference was in design, with only two studies achieving random allocation. However, even these struggled to achieve similar groups, due to differences in waiting times before admission to conditions. There was also a wide range in outcome measures, with little conformity between studies, leading to difficulties in making comparisons between interventions. There was often little justification for the measures chosen and less discussion about what constituted valid outcomes for interventions aimed at this patient group. Follow-up was generally poor, with half of the studies only assessing outcomes during the course of the intervention, and only one study following up after a year. Study retention rates were generally low, with just one study retaining more than 80% of participants.

2.5.3 Limitations

This review utilised a systematic approach to reviewing the literature and included studies with a wide range of designs. However, articles were limited to only those published in English language journals, thus excluding the grey

literature and articles published in other languages. Therefore, it is possible that, despite attempts to be as inclusive as possible, some key studies were omitted from this review. In addition, all the studies reviewed were carried out in the USA, making it hard to generalise findings to other countries and systems.

2.5.4 Implications for research

Future studies should include at least sequential allocation to conditions and closely monitor group make-up, to ensure that any differences can be controlled for statistically. The lack of conformity in outcome measures needs to be addressed, and is unlikely to be resolved without a discussion about what valid outcomes for homeless interventions are. This raises the broader question of what it means to escape from homelessness. Whilst carrying out follow-ups with this population is notoriously difficult, studies need to at least attempt it. Given high levels of relapse, follow-ups of at least one year would be desirable.

All the studies reviewed evaluated TCs in the USA, despite the fact that they are popular in the UK and across Europe. There is a pressing need for future research to evaluate TCs closer to home, to ascertain if they have any part to play in helping those who find themselves homeless.

This review has found little evidence in support of the claims being made for the effectiveness of TCs in treating a range of patients with dual diagnoses. However, the limitations of the studies reviewed mean that any conclusions drawn from their findings must be tentative. Homelessness in general is under-researched and more attention needs to be given to what interventions would best serve those who find themselves in this desperate state.

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Chapter Three: Reflective Paper

My Experience of Conducting Research with Once-Homeless Men: Reflections on therapists as researchers

Word count (excluding tables, figures and reference list): 3663

3.1 Introduction

In this paper, I have set out to reflect on my experience of carrying out research, as a trainee clinical psychologist, into the experiences of five men who have 'escaped' from homelessness. My interest in conducting this research was to explore what had worked for these men – what had allowed them to move from being homeless, living marginalised lives, to living lives that were much more mainstream and integrated with the rest of society.

The homeless are an especially significant group for me in terms of my journey in clinical training. I was working in a homeless hostel, nearly nine years ago, when I realised that I wanted to work with people who were struggling with mental health and addiction problems. It was this realisation that led me to embark on the long journey of training to be a clinical psychologist.

3.2 Homelessness research: My personal journey

In researching homelessness, I feel I am returning to where my journey towards clinical training started and perhaps looking for answers to some of the questions that I had at that time. Then, as now, the big question did not seem to be how people became homeless – listening to the life stories of the men and women living in the hostel, this did not seem to be hard to work out. What I really wanted to know was, what kept people trapped in homelessness and what would it take for them to escape? It was my desire to help people escape from homelessness, and the awareness that I did not have the understanding or the skills to do this, that made me decide to undertake clinical training. On reflection, it seems ironic that I have returned to where my journey in clinical training

started, just as I am nearing the end of the clinical psychology training programme.

Given the significance of this clinical area for me, it was to be expected that my experience of conducting this research would be something of an emotional roller-coaster. In common with many, no doubt, the research process itself has elicited a range of emotions. Initially, there were the lows of my struggles at the proposal and ethics stages. These were followed by difficulties with recruitment, which also served to illustrate just how difficult it was to escape from homelessness – those helping me (with years of experience of working with the homeless) were struggling to think of just two or three men who had managed this. Then came the high of the first competed interview, quickly followed by the fear that it would be the only one. And then, much later on, came the wonderful realisation that I had all the participants that I needed. It did not stop there though as, during the analysis and write-up stages, I struggled with trying to tease out the unique themes from five quite different escape stories and then weave them together in one coherent narrative.

As well as being affected by the research process, I was also touched by my encounters, through their escape stories, with the men themselves. And it would have been hard not to have been – their narratives contained much of the range of human experience: success, failure, death, loss, suffering, awful deprivation, hope, kindness: it was all there before me. I was inspired by their stories, their determination, their openness and honesty, and their hope for the future. I felt humbled by their accounts of what they had faced and survived, and privileged that they were sharing these very personal stories with me. I was in awe of them and of the wisdom that they had found on the difficult paths that they had trod.

And I also felt something of their sadness, the pain that they had suffered on their journey, and that still crept into their lives from time to time.

It is no surprise, then, that these stories have had an impact on me: I have not been untouched by what I have heard and seen in the lives of these men. Part of this experience was of identifying with them on a generalised person-to-person basis – we were humans, having the same basic needs and living fundamentally the same lives, on the same planet. But these men's experiences were also potentially the experiences of my father, uncles, cousins, nephews and even son, and this was another aspect of my identification with them. Their lives could have been the lives of people in my own family – things could so easily have worked out differently. And I could also identify with these men personally – I could see things that we had in common and spot times in my own life where I could have taken a 'wrong turn' that might have led into homelessness.

Looking back through my research diary at the entries I made after each interview, it is interesting to note that the overwhelming impression was of how much I enjoyed interviewing these men. Here are some of my comments after the first interview:

> Tom was a very engaging, thoughtful man who was happy to talk about his experiences. I was initially concerned that the interview would not go on for long enough, but in the end it was about 1½ hours in two parts.
>
> Really enjoyed the experience of talking to him – he was genuine, thoughtful and reflective...

It was the experience of talking to homeless men and women while working at a hostel that had launched me into clinical training. Now, as I talked to these once-

homeless men, I could see what it was that had attracted me to the idea of working with them in the first place.

However, I was not just personally touched by their stories, I was also fascinated by what these men had to say. They had achieved that rare thing: they had been homeless, three of them had slept rough – literally living on the streets – with all the deprivations that that entailed, and they had somehow escaped from all that. Not only that, but they were now living independently, working or studying full-time, and they were free of their addictions. These were men that had answers to the question of what it took for people to be able to escape from homelessness; they at least held the potential of answering that question for themselves. In addition, although there was some identification with them, these men had also experienced things that I had not experienced. They had been to depths of the soul that I had not been, and hope never to go. Some of the things they were describing were completely unfamiliar to be, and there was a sense that they had travelled in lands that I had never been to, and explored landscapes that I had never seen.

Along with all this, I was aware of another process: I was also relating to these men as potential patients. This is not so very surprising: nearly all of my recent experience of working with people in an interview setting has been as a clinician. In addition, these men had been through disturbing and traumatic experiences and were trying to make sense of them. Part of me, we can call it the therapist, wanted to help them do that, wanted to help them work through their pasts (both homeless and pre-homeless) and come to a ‘good place’ from which they could live out their future lives.

In summary, then, carrying out this research has thrown up a range of thoughts and feelings, all of which are potentially fruitful ground for further reflection. However, given the on-going debate about the role of clinical psychologists within the NHS and their potentially unique contribution as scientist-practitioners - perhaps more salient than ever in this new post-IAPT world - this is the area that I will focus on. In particular, I want to reflect on the experience of conducting research with these men from the position of being, primarily, a clinician – both by training and by inclination. Within this, I am especially interested in reflecting on the differences, and similarities, between what transpires in a therapeutic encounter and a research interview – both in theory and in practice. While there are certainly conflicts thrown up by being both therapist and researcher, I want to reflect on whether there may be benefits too. I am interested in exploring resolutions for the conflicts and making the most of the benefits. Other authors (e.g. David, 2006) have focussed on the practicalities of carrying out research as a clinician. Here, I am more concerned about whether therapists can make good researchers, not whether it is feasible for them to combine research with their clinical responsibilities. The question I want to reflect on is, to what degree do the skills and qualities that a 'good' therapist has equip them to carry out research or do they hold them back at all?

3.3 Therapists as researchers

3.3.1 Differences between research and therapy

As I have reflected on the process of carrying out this research, I have realised that I had begun this study having given far too little thought to the differences between therapeutic work and research. In fact, as I see it now, these endeavours

have two fundamentally different aims: the starting point for therapy is that the *status quo* is no longer tenable – the patient is there because he or she is unhappy with life as it is and is looking for change. Thus, the therapist aims to be catalyst for change, working with the patient to effect positive and lasting change in the patient's life. The researcher, on the other hand, is principally not looking to change, but to study, explore and generally gain a greater understanding of whatever is the phenomenon of interest. Although phenomenological research views the research interview as an interaction between interviewer and interviewee, with the resulting narrative a co-creation of the two (Finlay, 2009), the aim of this interaction is not to bring about change. The different aims of therapy and research are reflected in the different approaches and techniques used in clinical and research interviews.

3.3.1.1 Therapeutic work

In a clinical session, the therapist needs to use a range of 'skills' or 'techniques' to engage and develop rapport with the patient. Some of these, such as attention giving, observing and listening are not primarily interventative. However, techniques such as 'paraphrasing' and 'reflecting feelings' which are used to communicate to the client how he or she is perceived at the moment (Inskipp, 2006), are more likely to bring about change. Over time, as these skills are practised, they are likely to become second nature for a clinician and then there is the possibility that they may be used automatically. My last research had been over three years previously and since that time the majority of my work had been in clinical settings. Without realising it, my interview style had altered and was now much more appropriate to clinical than research work. This is illustrated in

an excerpt from my first interview, where Tom[1] is telling me about the circumstances in which he became homeless.

> Yeah, rang up the housing and said right I've had enough come and get it. Stayed at friends, here there and everywhere and even that, that annoyed me: stopping at friends. Ummm and I'd rather, I'd rather be on the street. Like I say, I'd rather stay in my own little world, I didn't want contact with , not even with my children you know, sisters, mother. Didn't .. that was it, that was my life, that was it. That was the way it was going to be....
>
> So .. it sounds like it was almost... a decision you made, it wasn't something that happened to you, it was almost like something you did because you, you just was fed-up for whatever reason with being in that kind of structure almost...

In my reply, I quite clearly practise the skill of paraphrasing, as I make my sense of what Tom was saying in the interview and check this out with him. Although paraphrasing may use some of the patient's language, its aim is to go beyond merely checking out meaning and it also includes elements of interpretation. It can help the patient to feel understood by the therapist and build rapport – an essential foundation for therapeutic work.

3.3.1.2 Conducting research

From a phenomenological research perspective, techniques like paraphrasing run the risk of shaping what the participant has to say in line with what the interviewer thinks about it. Thus, the participant's account of an experience may be 'polluted' by the sense that the interviewer makes of it. In the research interview, the focus is on facilitating interviewees to "tell their own stories, in their own words" (Smith, Flowers & Larkin 2009, p. 57). There is still the need to try to make sense of the participant's account in research of course, but this

[1] Pseudonyms are used throughout, to preserve anonymity.

should be confined to the analysis stage. In the interview, the researcher's goal is to explore what the participant is saying, helping them to speak about it as fully as possible. There is still scope for checking meaning, but it needs to be done in a way that is close to the participant's own language, as in the following example – also from my interview with Tom. Here, Tom is talking to me about his experience of being homeless and what that was like for him.

> That kind, them kind.... all I was focussed on ummm, I just, I didn't really care whether I'd.. I had a place to go or not, I'd always … I could fall asleep.. on the street, that was me ...Um you're kind of numb inside, you don't ... you're numb to everything. You... it's hard to describe, I didn't care about being homeless, I was just it, it might enter your head quickly and then as soon as it comes, it go.....So it didn't matter to me
>
> So it didn't bother you that you didn't have anywhere to sleep, because you could find somewhere? Is that what you're saying?

Rather than paraphrasing what I think Tom had said, and risk imposing my meaning on it, I asked a question to check meaning, using the word 'bother' which Tom had already used several times in the interview.

During the process of analysing and transcribing the interviews, and through making notes in my reflexive diary, I realised that there were times during the interviews where I did not behave as I would have done in a therapeutic setting. One example of this came when 'John' was talking about being blamed by his partner's parents for her death while he was in prison.

> I could have done better. I shouldn't have been committing crime, but we were both on drugs, we knew what we both doing. [unintelligible] but if I'd have got off drugs, I could have helped her. Maybe it wouldn't have been this mess. Maybe

> it, was the drugs, the drugs that made her have a heart attack. I don't know. [pause]

I was acutely aware that John was quite emotionally stirred up by his recall of this incident, and it seemed clear that he blamed himself to some extent for his partner's death. However, as it was a research interview, and not a clinical one, I was not able to offer the degree of empathy that I would normally. This was an uncomfortable experience for me and unsatisfying clinically as it seemed like an opportunity lost. My feeling is that this kind of experience is likely to result in clinicians being less inclined to carry out research.

3.3.1.3 Supervision

My questioning style was picked up by my supervisor who read the full transcript of my first interview, highlighting the importance of good supervision when doing research of this kind. As in clinical work, supervision in research provides the 'other' perspective that Bolton (2005) argues is so important for effective reflection to take place. Introducing this perspective into the heart of clinical and research work can make us feel vulnerable, especially if recordings or transcripts of sessions are given to supervisors, yet time and time again I have seen how valuable it is. Although supervision is a key way of doing this, peer discussion and thoughtfully reading accounts of other researchers and clinicians practice can also be useful. In this case, my supervisor's comments prompted me to reflect on the approach I had used in some of my questions and helped me to realise that at times I was slipping into a clinical mode of interviewing. This was the starting point for further reflections on the ways in which clinical and research interviews differed.

Research supervision also has the potential to provide a safe place for the researcher, where he or she can talk about their experience of conducting the research and the impact it has had on them. This is likely to be more important for some studies than others – for example where participants have been talking about traumatic experiences the researcher is at risk of being vicariously traumatised by listening to them.

3.3.2 Similarities between research and therapy

Although there are differences in aim between research and therapy, there are also similarities in the way that these aims are achieved. Therapy and social science research are both essentially human endeavours, and doing good research, especially good qualitative research, requires developing rapport with the participant. If the participant does not feel comfortable with the researcher, or is unsure if they can trust them, then the interview is unlikely to lead to 'good data' (Smith et al., 2009).

Although my clinical skills, used automatically at the start of the interview with Tom, created some initial problems, I also feel that they were an asset as I sought to engage with participants. The focus of my research was my participants' escape from homelessness, but I was also asking them to talk about their experience of being homeless. For all of them, this had been a difficult and challenging time and it was important that they felt as safe and as comfortable as possible as they told these stories. The more open and honest they felt able to be with me, the closer their account would be to the ‘lived experience’ that I was interested in. In this respect, the research interview has a lot in common with the clinical one. In the clinical interview too, the patient will be talking about

difficult aspects of their lives, perhaps for the first time. They too will need to feel safe and contained by the therapist if they are going to risk making themselves feel vulnerable in this way.

It is also possible that therapists' clinical experience might mean that they are more tuned into cues indicating that the interview has strayed into difficult or uncomfortable areas. Missing these signs and continuing to question the participant could lead to a break down of the interview, or even harm to the participant. Although I was not interviewing a clinical population, I was aware that the men I was talking to had been through potentially traumatising experiences. In addition, as my participants had escaped from homelessness, I needed to ensure that I did nothing that would question or threaten that escape. I had the distinct feeling that some of my participants were more securely escaped than others, and I was especially careful, when interviewing those who seemed more vulnerable, not to be too challenging in my questioning.

3.4 Conclusions

With a clearer understanding of the differences between therapeutic and research questioning, I can now see that it would have been useful to have explicitly oriented myself to a more research-focussed approach before starting interviewing. Each research approach, of course, emphasises different aspects of the interview, but my initial interview could have benefited from a more careful use of the participant’s own language and less summarising of the content using language that I was more comfortable with. This orienting, or re-orienting, is likely to be a useful exercise for all of us who conduct research as part of a dual-

role post. It is likely to be especially useful when starting a new piece of work, but also from time to time as a piece of research is progressing.

I have seen, too, how important supervision is, not just for 'scientist-practitioners', but for all who want to carry out high quality research. Not only were the comments about my interviewing style helpful, my supervisor also checked my analysis to ensure that my interpretations were always grounded in the data. Supervision can also provide a safe place for the researcher to reflect on their experience of the research, this is especially important when working with traumatised participants.

Clinicians bring a range of engagement and rapport-building skills that are invaluable when doing social sciences research, especially qualitative research. Clinicians are also well-placed to care for the more vulnerable participants and, perhaps, better equipped to spot signs that they are becoming uncomfortable and even distressed by the interview.

In addition to the need to adjust their approach, research can also be challenging for therapists as it does not allow them to engage in such a helpful way with the participant. This may result in research being an unsatisfying experience for some. One way of mitigating against this would be to ensure that when research is conducted with potentially vulnerable individuals, they are first engaged wherever possible in a therapeutic service. This would allow issues raised in the research interview to be explored therapeutically and, in addition to making it easier for the therapist-researcher, would also make it easier to uphold the ethical principle of doing no harm to the participant.

In summary, then, therapists have a range of skills which are likely to bring benefit to their research. However, clinicians need to be aware of the clear differences in research and therapeutic aims and would benefit from an explicit re-orientation to the research approach when beginning any new study.

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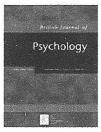
Appendix A

Author Instructions for British Journal of Psychology

British Journal of Psychology



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(a) reports of empirical studies likely to further our understanding of psychology

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The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

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Papers should normally be no more than 8000 words (excluding the abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

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• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

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• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

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Appendix B

Participation Information Sheets

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Doctorate Course in Clinical Psychology
Dr Eve Knight
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THE UNIVERSITY OF WARWICK

Coventry University

ESCAPING FROM HOMELESSNESS

INFORMATION ABOUT THIS STUDY

1. *Background to this study*

I am doing this research because I'm interested in the lives of people who used to be homeless. I'm especially interested in what people think has helped them to 'move on' from being homeless.

For this study, I'm going to interview about 6 people. I'm going to ask them about being homeless and what helped them to 'escape' from homelessness.

I'm a Trainee Clinical Psychologist studying at the Universities of Coventry and Warwick. I am doing this research as part of my training.

2. *Why me?*

I've contacted you because you were homeless in the past and you've now moved on. I'm interested in finding out about how people recover from homelessness and I'd like to talk to you about how you did this.

3. *Do I have to take part?*

It's up to you whether you take part in this study or not. You should only agree to take part if you want to.

If you want to stop the interview at any time, you can. You don't have to give a reason. You can carry on later if you want to, but you don't have to.

Even if you decide to do the interview, you can still leave the study for up to **one month** after your interview.

4. *What do I have to do?*

If you take part in the study, you will be asked some questions about being homeless, and escaping from homelessness. How long the interview takes will depend on how much you have to say. It'll probably take about 1 to 1½ hours.

After the first interview, I'll ask you if you'd be happy to take part in a second interview. If you had a second interview, I'd be asking you about things other people talked about which you didn't. Or I might ask for more detail about something you mentioned briefly. A second interview would be shorter, probably less than an hour.

Both interviews will be recorded using a digital audio recorder.

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If there's anything you don't want to talk about, then you can say so. Also, if you decide you don't want to continue with the interview, then that's ok too.

At the end, I'll ask you to fill in a form giving some information about yourself and how long you were homeless for.

5. ***What are the risks of taking part in this study?***

I'll be asking you about being homeless. Thinking and talking about difficult memories from this time might upset you.

6. ***What are the benefits of taking part?***

You'll have the chance to talk to someone about moving on from being homeless. This might help you to think about being homeless and what you've learnt from it.

I'm going to write up the results of this study and try to get them published in a psychology journal. This might help people working with the homeless to have a better understanding of what helps them to move on.

7. ***Can I leave the study?***

You can pull out of the study at any time during the interview, without giving a reason. Leaving the study won't affect the support you receive from any services.

If you change your mind about taking part, you can still leave the study for up to **one month** after your interview. You just need to get in touch with me. Leaving the study will mean that all information that you gave, including your interview, will be destroyed.

8. ***Data protection and confidentiality***

I won't tell anyone that you've taken part in this study, or if you decide to leave it.

When I type out the interview, I'll take out anything (including your name) that could identify you. I might quote your words when I write up the study, but it shouldn't be possible to trace them back to you. You'll get the chance to check you're happy with any quotes from your interview I want to use.

The interview recording will be kept on a password-protected laptop. I will password-protect each interview to improve security.

I'll delete the recording of your interview at the end of the study and will only keep the written out version, with names etc. taken out.

I won't talk about anything you say in a way that will identify you. However, if you say anything that makes me think someone vulnerable might be harmed, I'll have to pass on this information to my supervisors or other relevant people.

Version 1.1 8/11/10

9. What if things go wrong? Who to complain to

If you start to feel uncomfortable or upset during the interview, you can stop the interview. You can carry on later if you want to, but you don't have to.

If you're unhappy with the way the study has been carried out, or with the way you've been treated, you can tell me about it.

If you don't want to talk to me, or you're unhappy with what I say, you can complain to Dr Adrian Neal at Coventry University. His details are at the end of this sheet.

10. What will happen to the results of this study?

I'm going to write up the findings from this study as a formal report and hand it in to the Universities of Coventry and Warwick. I'll also try to get it published in a psychology journal.

I'm going to send a written summary of the results to everyone who took part in the study. I'll also present the results of this study to the staff that were involved with it.

11. Who has reviewed this study?

University researchers and clinical psychologists have checked this study to make sure that it meets the required standard. Coventry University's Applied Research Committee has also approved it.

12. Key contacts

The chief researcher for this study is Bill Morgan, Trainee Clinical Psychologist. Dr Adrian Neal, Clinical Psychologist, is my supervisor at Coventry University.

Both of us can be contacted at:

Clinical Psychology Doctorate Programme
Coventry University
Room JSG24, James Starley Building
Priory Street
Coventry
CV1 5FB

Tel: 024 76887806

Appendix C

Semi-structured Interview

ESCAPING FROM HOMELESSNESS

SEMI-STRUCTURED INTERVIEW

The route into homelessness

- What do you think led to you becoming homeless?
  - What was the main thing?
  - Do you think *you* had any part in your becoming homeless?

Experience of being homeless

- What was being homeless like for you?
  - What was it like initially?
  - Did things change at all?
- What do you think it was that kept you homeless?
  - What might have helped you to escape?

Moving out of homelessness

- Can you tell me about your move out of homelessness?
  - How did that happen?
  - What do you think brought that about?
- What do you think helped you to escape from homelessness?
  - Were there any specific things that happened (critical incidents)?
    Can you describe these - try to imagine being there again and talk through what it felt like, what it meant, what you did etc
  - Do you think anything changed about you – your attitudes, beliefs, feelings?
  - Do you think anything helped you to change?
  - Did you get any help from people or services which was important?

Life after homelessness

- So how's your life now?
  - Is there anything you feel you still need help with?
  - What's working for you?
  - What's important for keeping your life 'on track'?

Version 1.1 25/6/10

Appendix D

Consent Form

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

ESCAPING FROM HOMELESSNESS

CONSENT FORM

This study is interested in finding out how some people have managed to escape from being homeless. To do this, it will ask people about their experiences of being homeless and escaping from homelessness.

	Please tick
I've read and understood the information sheets for this study. I've had the chance to ask questions.	☐
I know I don't have take part in this study. I'm also free to leave at any time without giving a reason.	☐
I understand no one will be told I've taken part in this study. I understand that anything I say that could identify me will be taken out when my interview is typed up.	☐
I know I have the right to change my mind about taking part in the study for up to **one month** after my interview.	☐
I understand I'll have the chance to check I'm happy with any quotes from my interview that will be used.	☐
I agree to be recorded as part of the research project.	☐
I have been given contact details for the people involved with this study. I know what to do if I have a complaint.	☐
I agree to take part in the research project.	☐

Name of participant: .....

Signature of participant: .....

Date: .....

Name of researcher: .....

Signature of researcher: .....

Date: .....

Version 1.0 6/6/10

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology
Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

www.coventry.ac.uk

Appendix E

Demographic Information Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

ESCAPING FROM HOMELESSNESS

DEMOGRAPHIC INFORMATION SHEET

Name: _____ Age:____ Sex: M/F

Please tick the box that best describes your ethnic origin:

White British	☐	Asian / Asian British: Pakistani	☐
White Irish	☐	Asian / Asian British: Indian	☐
White Other	☐	Asian / Asian British: Other	☐
Mixed White and Black Caribbean	☐	Black / Black British: Caribbean	☐
Mixed White and Black African	☐	Black / Black British: African	☐
Mixed White and Asian	☐	Black / Black British: Other	☐
Mixed Other	☐	Chinese	☐
Asian / Asian British: Bangladeshi	☐	Other	☐

Which country were you born in? _____

Questions about when you were homeless

How old were you when you first became homeless? _____

How many times have you been homeless? _____

What's the longest time you've been homeless for? _____

What's the **total** time you've been homeless for? _____

How long is it since you were last homeless? _____

What types of homelessness have you experienced – please tick all that apply

Rough sleeping	☐	Night shelter	☐
Hostel	☐	Friends' or family's sofa/floor	☐
Other	☐	_____	

Questions about your life now

How long have you been living in your current accommodation? _____

What is your current occupation? _____

How long have you been doing this for? _____

Version 1.0 6/6/10

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology
Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

www.coventry.ac.uk

Appendix F

Debriefing Sheet

Coventry University
Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

Programme Director
Doctorate Course in Clinical Psychology
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

THE UNIVERSITY OF WARWICK

Coventry University

ESCAPING FROM HOMELESSNESS

DEBRIEFING SHEET

What happens next?

Your interview recording

I'm going to type up the recording of your interview, and take out all information that could identify you.

You can leave the study, taking all of your information out of it, for up to **one month** after your interview.

Once the study is over, I'll delete the recording of your interview. I'll keep the typed up copy though.

Findings of the study

I'm going to write up this research as a formal report to hand in to the Universities of Coventry and Warwick. I will contact you to check that you're happy with any quotes from your interview that I want to use in this report.

I'll also try to get the report published in a psychological journal. I'm going to send a written summary of the results to everyone who's taken part. I'll also present the results of the study to the staff involved in it.

Complaints/comments

If you're unhappy with any part of this study, then you have the right to make a complaint.

If you want to you can talk to me about your complaint to start with. But you don't have to tell me about it.

If you don't want to talk to me, or you're unhappy with what I say, you can contact Dr Adrian Neal at Coventry University. If you're not happy with what he says, you can ask him how to take your complaint further.

Contact details

Bill Morgan – principal investigator
Coventry University
Room JSG24, James Starley Building
Priory Street
Coventry
CV1 5FB

Tel: 024 76 887 806

Dr Adrian Neal – staff supervisor
Coventry University
Room JSG24, James Starley Building
Priory Street
Coventry
CV1 5FB

Tel: 024 76 887 806

Version 1.0 6/6/10

Dean of Faculty of Health and Life Sciences
Dr Linda Merriman Mphil PhD DpodM CertEd Coventry University Priory Street Coventry CV1 5FB Tel 024 7679 5805

Chair of Department of Psychology
Professor Liz Robinson BSc PhD University of Warwick Coventry CV4 7AL Tel 024 7652 3096

www.coventry.ac.uk

Support Services

You may have found talking about being homeless upsetting. Or you might want to talk to someone in more depth about your experiences of being homeless. In either case, your GP should be able to put you in touch with services that can help.

If you want to talk to a counsellor, but don't want to go through a GP, then the organisations listed below might be able to help.

They're not connected with this study and anything you say to them will be confidential.

Samaritans

Chris
P.O. Box 9090
Stirling
FK8 2SA
Tel: 08457 90 90 90

St Martin's Centre for Health & Healing

St Martin in the Bullring
Bullring
Birmingham
B5 5BB
Tel: 0121 600 6026

Version 1.0 6/6/10

Appendix G

Example of Initial Analysis

Extracts grouped by theme

Transcription Tom

Right Tom, could you start off by telling me a little bit about yourself, 'cos I don't really know very much about you at all

Er, er.....

It'd be useful to get some idea of, yeah ..... who you are really

Well... who I am... I'm ahhh, I'll be 47 in December, born in '63, born in Cyprus, my Dad was in the RAF out there... Umm come back to England when I was one, been a Birmingham lad all my life really... um, well ahhh Irish descent. I'm divorced, about 6 years ago, got 4 children; 3 girls and a boy.... Umm I was with my partner for about 27 years, we, I was 14 she was 13 when we first met, and that was it all the way through....I always worked err mainly on the building trade, painting and decorating I.. Erm..... always been a drinker really... Err suffered real bad depression, ended up in hospital at one stage through depression.... And then kind of then went through a messy divorce and breakup and .....just became um an alcoholic really... and kind of give up on myself and everything around me... which was easier for me...so I didn't have anyone to answer to except myself... So ...um.... and just went into my own world.... and I didn't want anyone to come into my world and that was where I was sleeping and that was my life.... Until I had the, I nearly died, emmm was picked up off the streets So the consultant told me, I was a couple of days, if they hadn't got me within a day or two days at the most, I'd have been dead... I had alcohol poisoning, lost about 4 ½ stone ... I had hardly any oxygen in my blood ummm, my heart rate was all over the place... Well it took 3 ½ weeks in Selly Oak hospital for me to even... well it took 2 weeks for me to even sit up in bed... Umm I was there

1

Transcription Tom

for about 3 ½ weeks.... Umm , the rest, up until today's .. history really.. So that's a brief ...

Yeah, ok, well thanks for that it's helpful to kind of quick overview of how things have been really. Umm, if we can start at the beginning really, I suppose in terms of what this research is about... What do you think it was that ...ummm led to you becoming homeless...What, what was going on....

Homeless? [Yeah] Ummm I think the thing that led to me becoming homeless. Well I think I know really ... is because I didn't want to have any contact with any kind of ....err authority or anything like that, I just wanted to be myself.... So ... I just went like I say, I just went into my own little world and I was safe in my own little world, I didn't want a place, I was quite happy to freeze and sleep in bus shelters and parks and ...umm it was.... yeah, and the breakup of the marriage and things, you know, I just couldn't with it all: the grief, the stress, the ..... And yeah, I just went into my own world... That's why I, that's how I became homeless...

own world

So before you became homeless, where were you living?

Didn't pick up on 'own little world'

I had a flat. Ummm which was, quite nice cosy.....I don't... I just seem yeah I gave it all up, left it one day and that was it.. And ...

So you just walked out?

Yeah, rang up the housing and said right I've had enough come and get it. Stayed at friends, here there and everywhere and even that, that annoyed me: stopping at friends. Ummm and I'd rather, I'd rather be on the street. Like I say, I'd rather stay in my own little world, I didn't want contact with , not even with my

own world

homelessness a way of escaping/recreating – he says from 'authority' here, but I wonder if boundaries are what

breakup of marriage = grief stress (a feature??)

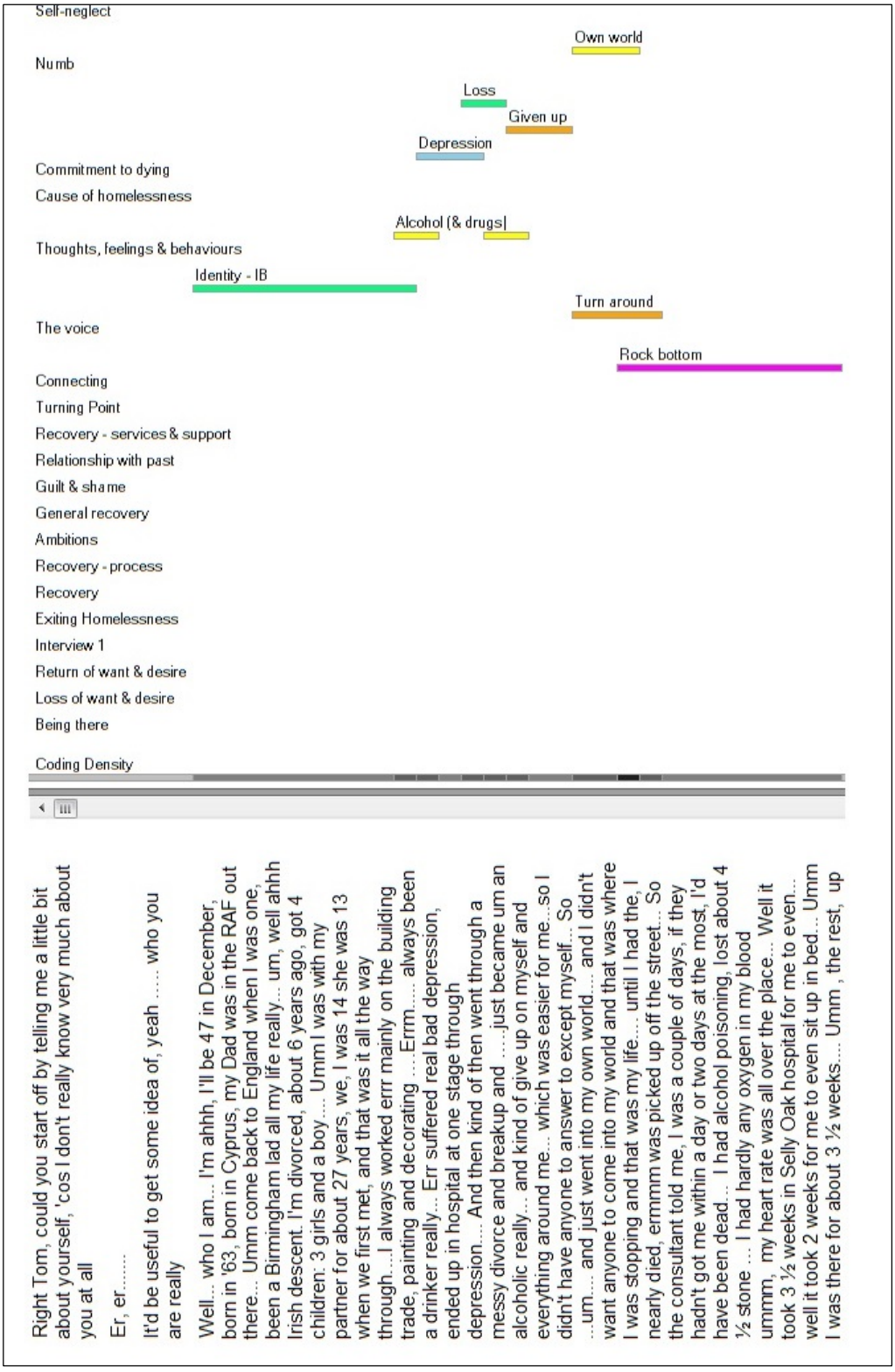
angry at mum?

a very small world : a world of 1 !

Wanted to get away from it all – sleeping on streets & alcohol me but he'd do.

Appendix H

Example of NVivo Coding



Self-pity
Self-neglect
Own world
Numb
Loss
Given up
Depression
Commitment to dying
Cause of homelessness
Alcohol (& drugs|
Thoughts, feelings & behaviours
Identity - IB
Turn around
The voice
Rock bottom
Connecting
Turning Point
Recovery - services & support
Relationship with past
Guilt & shame
General recovery
Ambitions
Recovery - process
Recovery
Exiting Homelessness
Interview 1
Return of want & desire
Loss of want & desire
Being there
Coding Density
until today's ... history really.. So that's a brief ....
Yeah, ok, well thanks for that it's helpful to kind of quick overview of how things have been really. Umm, if we can start at the beginning really, I suppose in terms of what this research is about... What do you think it was that ...ummm led to you becoming homeless...What, what was going on....
Homeless? [Yeah] Ummm I think the thing that led to me becoming homeless. Well I think I know really ... is because I didn't want to have any contact with any kind of ....err authority or anything like that, I just wanted to be myself.... So ... I just went like I say, I just went into my own little world and I was safe in my own little world, I didn't want a place, I was quite happy to freeze and sleep in bus shelters and parks and ...umm it was.... yeah, and the breakup of the marriage and things, you know, I just couldn't with it all: the grief, the stress, the ..... And yeah, I just went into my own world... That's why I, that's how I became homeless...
So before you became homeless, where were you living?
I had a flat. Ummm which was, quite nice cosy.....I don't... I just seem yeah I gave it all up, left it one day and that was it.. And ...
So you just walked out?
Yeah, rang up the housing and said right I've had enough come and get it. Stayed at friends, here there and everywhere and even that, that annoyed me: stopping at friends. Ummm and I'd rather, I'd rather be on the street. Like I say, I'd rather stay in my own little world, I didn't want contact with , not even with my

Appendix I

Example of Table of Themes

Rock Bottom/Turning Point Themes

Rock bottom

This was the low-point – physically and mentally – that Tom reached which resulted in him collapsing and being admitted into hospital

Theme	Indicative quote	Ref
Rock bottom	I still remember, how my face hit the pavement … but it was like hitting that [cushion of the sofa] , it was soft. And I just said, "This is it now, thank God." It was like I say, I had been really bad a couple of weeks before that, my body had … I was over the park, I didn't even care, it come into my mind, "No one's even going to find you now." 'Cos I was fitting, my whole, it felt as if my eyeballs were shaking in my head.	15:27f

Turning Point

This is do with the experiences that Tom had around the time that he was in hospital that left him with the conviction that he was not going to drink again.

Theme	Indicative quote	Ref
The Voice	And then err…,,,whi[le] I, I thought I was dead anyway, but I kept on hearing someone telling to me, saying to me, that um, "You're not dead Tom, just get up. It's time to get up now. You're not dead Tom, it's time to get up, now. Stop this now, it's time to get up." And …..ummm I don't know what it was inside me, and everything just …. it made me get up really.	13:5f
Connecting	And errr, … and it's a, it 's a funny thing when … A lot of people can speak, but when you listen to somebody - there could be 10 people in the room speaking - and when you listen to this one person, then all the sudden they seem to connect, or you connect with what they're saying, and it really makes sense and they explain it and it's clear and you tend to listen a lot harder I think. … So, yeah, it was kind of him really ..	13:22f
Turn around	But it all, it also seemed, when I was … it also seemed so severe for me from being one way to the other way …. and all that changed when I went to hospital. I mean 'cos it……north pole, south pole you know, it …. there was no in between it was just that way or it's this way …. you didn't you know ….. and I can't, I just can't work that out … But I knew I was not going to drink when I come out of hospital … that was already firmly planted in my mind …. but , yeah …	27:7f

1

Appendix J

Ethical Approval Form

REGISTRY RESEARCH UNIT

ETHICS REVIEW FEEDBACK FORM

(Review feedback should be completed within 10 working days)

Name of applicant: William Morgan **Faculty/School/Department:** Clinical Psychology: HLS

Research project title: Escaping Homelessness

Comments by the reviewer

1. Evaluation of the ethics of the proposal:

This ethical considerations relating to this project have been thoroughly considered. The project involves interviewing adults who have, at one time in their lives, been homeless. It adopts a positive stance in focussing on how people have escaped from homelessness and has clear implications for psychology and the future well being of this, often difficult to access, population.

2. Evaluation of the participant information sheet and consent form:

The participation information sheet and consent form are very thorough, well written and clearly presented. All the appropriate consents are considered.

3. Recommendation:

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

- [√] Approved - no conditions attached
- [ ] Approved with minor conditions (no need to resubmit)
- [ ] Conditional upon the following – please use additional sheets if necessary (please re-submit application)
- [ ] Rejected for the following reason(s) – please use other side if necessary
- [ ] Further advice/notes - please use other side if necessary

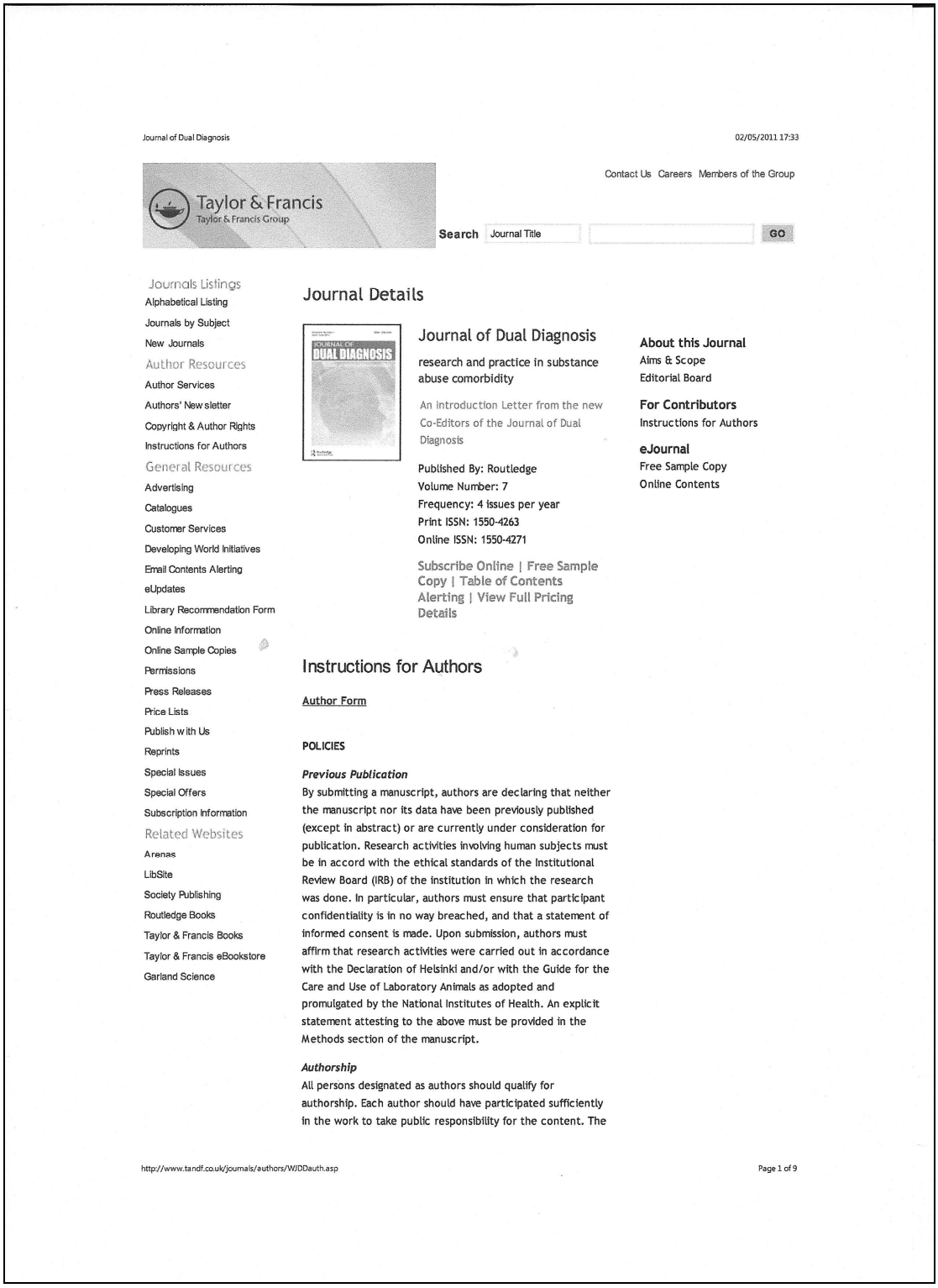
Name of reviewer: Dr Eve Knight

Signature: .....

Date: 9th June 2010

Appendix K

Author Instructions for Journal of Dual Diagnosis



Journal Details

Journal of Dual Diagnosis

research and practice in substance abuse comorbidity

An Introduction Letter from the new Co-Editors of the Journal of Dual Diagnosis

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Instructions for Authors

Author Form

POLICIES

Previous Publication

By submitting a manuscript, authors are declaring that neither the manuscript nor its data have been previously published (except in abstract) or are currently under consideration for publication. Research activities involving human subjects must be in accord with the ethical standards of the institutional Review Board (IRB) of the institution in which the research was done. In particular, authors must ensure that participant confidentiality is in no way breached, and that a statement of informed consent is made. Upon submission, authors must affirm that research activities were carried out in accordance with the Declaration of Helsinki and/or with the Guide for the Care and Use of Laboratory Animals as adopted and promulgated by the National Institutes of Health. An explicit statement attesting to the above must be provided in the Methods section of the manuscript.

Authorship

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the content. The

corresponding author affirms that he or she had access to all data from the study, both what is reported and what is unreported, and also that he or she had complete freedom to direct its analysis and its reporting, without influence from the sponsors. The corresponding author also affirms that there was no editorial direction or censorship from the sponsors. Preparation of drafts of manuscripts by employees of the sponsor who are not listed as authors is expressly prohibited.

Authorship credit should be based on:

1. Substantial contributions to conception and design or analysis and interpretation of data.
2. Substantial contributions to drafting the article or revising it critically for important intellectual content.
3. Final approval of the version to be published
4. Participation was not limited only to the acquisition of funding for the research or position as chair or director of a relevant department, division, or research group.

All four conditions must be met. Participation solely in the acquisition of funding or the collection of data does not justify authorship. General supervision of the research group is also not sufficient. Any part of an article critical to its main conclusions must be the responsibility of at least one author. Only those with key responsibility for the material in the article should be listed as authors; others contributing to the work should be recognized in the Acknowledgments section.

Disclosure of Potential Conflicts of Interest

The submission must contain an explicit and unambiguous statement describing any potential conflict of interest, or lack thereof, for all of the authors as it relates to the subject of the article. Examples include: "Dr. Smith reports no financial relationships with commercial interests." "Dr. Smith receives compensation as a consultant for XYZ Company, a manufacturer of antidepressants." "Dr. Jones and Dr. Smith have financial holdings in ABC Company, which distributes haloperidol." "Dr. Jones owns a patent on the diagnostic device described in this article." These statements acknowledging or denying conflicts of interest must be included in the manuscript under the heading "Disclosures," which should appear just before "References."

There must also be a listing for each author, detailing the names of organizations, institutions, companies, and individuals from whom they have received compensation for professional services in any of the previous three years, or from whom they anticipate receiving such compensation in the near future, whether or not these affiliations appear to have any relevance to the topic covered in the submission. Neither the precise amount received from each entity nor the aggregate income from these sources needs to be provided. Professional services include any activities for which the individual is, has been, or will be compensated with cash,

royalties, fees, stock or stock options in exchange for work performed, advice or counsel provided, or for other services related to the author's professional knowledge and skills. This would include, but not necessarily be limited to, the identification of organizations from which the author received contracts or in which he or she holds an equity stake if professional services were provided in conjunction with the transaction. The authors are expected to disclose any other financial holdings or considerations, such as stocks, bonds or donations of supplies or equipment that a reasonable person could construe as possibly influencing the objectivity of the report.

The ***Journal of Dual Diagnosis*** will not make specific recommendations as to whether a relationship requires disclosing. If there is a question as to whether a relationship is relevant, disclosure is the preferred course of action.

The Editors will review all author statements of financial support to determine if there is evidence of bias from these sources. If it appears that there may be, then further review and possible rejection of the manuscript may occur. Authors are encouraged to contact the Editor at any stage in the manuscript review process if they believe that they have relationships that require review.

Registration of Clinical Trials

Broad access to the research literature and the rights of our authors are important to *Journal of Dual Diagnosis*. The Journal subscribes to the standards set by the International Committee of Medical Journal Editors in *The Lancet* (364: 911-912, 2004) requiring that all trials that start enrolling participants after July 1, 2005 must be registered in a suitable publicly accessible register before the initiation of enrollment in order to be considered for publication in the Journal. Those trials that started enrollment before July 1, 2005 must have registered before September 13, 2005 to be considered for publication. Suggested registers include: http://www.clinicaltrials.gov and http://www.controlled-trials.com. Registration in the former is free, while registration for trials that do not emanate from developing countries carries a $144 charge in the latter. Access to both registries is free.

MANUSCRIPT PREPARATION AND SUBMISSION

Send completed manuscripts, including all relevant items listed below, to Stephanie Acquilano, Managing Editor, at stephanie.acquilano@dartmouth.edu. The Journal will accept electronic submissions only. Submissions missing any relevant items will not be reviewed until complete.

General

Manuscripts should be prepared in accordance with the *Publication Manual of the American Psychological Association*, Sixth Edition. The manuscript (except tables and figures) must be formatted with one-inch margins all around, double-

spaced, and font Times New Roman 12. All pages must be numbered. Use jargon and abbreviations sparingly. Use active voice, first person, and short sentences whenever possible. Language should be gender-neutral.

Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author, you are required to secure permission if you want to reproduce any figure, table, or extract from the text of another source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher.

Types of Submissions

The ***Journal of Dual Diagnosis*** will accept a range of manuscripts for consideration. These are described below. All word limitations refer only to the "Text" section of the manuscript (i.e., Introduction, Methods, Results, and Discussion).

Articles (research and non-research reports)
Articles should not exceed 3,500 words, although some exceptions may be granted by the Editors. Generally, articles will be research reports of original work, presenting new data based on a relative large number of participants. Appropriate research will follow the highest scientific standards and offer important advances in the field of co-occurring disorders.

Brief Reports
Brief Reports should not exceed 2,000 words. These manuscripts are typically reports of research based on a relatively small number of participants, or of research yielding important information for the field of co-occurring disorders despite substantial limitations.

Literature Reviews
Reviews will typically be invited by the Editors, but the Journal will accept unsolicited manuscripts. Reviews should not exceed 7,000 words in length, should focus on recent literature, and should synthesize important information on a topic of special interest to the field of co-occurring disorders.

Editorials
While editorials will typically be invited by the Editors, the Journal will accept uninvited commentaries of less than 1,000 words.

Clinical Reviews
Clinical reviews will be included in the "Clinical Forum" section of the Journal. Clinical reviews should present high-quality literature reviews on a topic of substantial importance in the clinical care of individuals with co-occurring disorders,

along with a case description that illustrates the major features of the topic. Both invited and uninvited manuscripts that conform to this format will be accepted for review. Manuscripts submitted for the Clinical Forum section should not exceed 3,500 words, and should lead with the case description followed by the literature review.

Letters to the Editors

Letters should not exceed 500 words and will be published at the discretion of the Editors. Case reports that are not supported by a literature review and synthesis may be submitted as a letter.

Format of Submissions

Submissions to the Journal must include at least three parts: (1) cover memo, (2) manuscript (with tables and figures included at the end of the document), and (3) signed author forms from all authors. Specific instructions for each are below.

1. Cover Memo

The corresponding author must state that neither the manuscript nor its data have been previously published (except in abstract) or are currently under consideration for publication, and that the manuscript will become the property of the Journal while under review and when or if the manuscript is accepted for publication. This can be done within a separate cover memo or as part of the email that accompanies the manuscript. In addition, the memo should include what type of manuscript is being submitted and the names and email addresses of three experts as possible reviewers for the manuscript.

2. Manuscript

Title Page

The title should describe the content of the manuscript as briefly as possible. The title page should contain the full names of authors and highest degree, academic or professional affiliations, and e-mail addresses for each. Include the complete address, telephone number, fax number, and e-mail address of the author to whom correspondence should be sent.

Abstract Page

The abstract should be structured and should include the following information under the headings indicated: Objective - the primary purpose of the article; Methods - data sources, participants, design, measurements, data analysis (for review articles it will be important to specify the methods of literature search and selection); Results - key findings; and Conclusions - implications and future directions. For regular articles, the abstract should not exceed 250 words. For brief reports, the limit is 150 words. The abstract does not need to be structured for non-research articles. The abstract should be followed by a list of 3-10 key words.

Text

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